

Care Quality Commission

Inspection Evidence Table

Dunster Surgery (1-2418458072)

Inspection date: 17 & 18 October 2018

Date of data download: 04 October 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y
Disclosure and Barring Service checks were undertaken where required	Y
The safeguarding lead had completed level 4 children's safeguarding training.	
The practice had a medicines delivery service to local drop-off sites. Recently the service had commenced home delivery of some medicines. There was no risk assessment in place regarding the risk when delivering to vulnerable and isolated patients. Following inspection, the practice confirmed a DBS check for the driver had been applied for.	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place	Y
Following a recent outbreak of measles, the practice had revisited staff vaccination histories, sought professional advice and offered additional MMR vaccination to ensure staff were immunised using the most up to date vaccination scheme.	

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: May 2018	Y
There was a record of equipment calibration Date of last calibration: May 2018	Y
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y
Fire alarm checks	Y
Fire training for staff	Y
Fire marshals	Y
Fire risk assessment Date of completion: August 2018	Y
Actions were identified and completed such as a programme to test emergency lighting in darkness.	Y
Additional observations: The practice had developed a door hanger for use in case of a fire. When the alarm sounded clinicians leaving their rooms placed a room empty sign on the door. Fire marshals were then able to check other areas such as toilets and ensure each room had been identified as being empty. They ensured they had enough trained fire marshals on duty so during building evacuation the fire marshals could work in pairs to clear the practice.	Y
Health and safety Premises/security risk assessment? Date of last assessment: September 2018	Y
Health and safety risk assessment and actions Date of last assessment: September 2018	Y
Additional comments: The practice had updated their business continuity plan regularly to include additional risks they had experienced such as service disruption from heavy snow; infectious disease outbreaks.	

Infection control	Y/N
<p>Risk assessment and policy in place</p> <p>Date of last infection control audit: March 2018</p> <p>One issue was identified: Not all clinical waste bags were labelled and securely sealed before disposal the practice acted on any issues identified.</p>	Y
The arrangements for managing waste and clinical specimens kept people safe?	Partial
The practice was disposing of hormonal medicines for injection within the wrong sharps waste receptacle. This was addressed following inspection.	
Any additional evidence	
The practice produced an annual infection, prevention and control statement which was available on their website.	

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
<p>As a result of a significant event following delays to two-week wait (2WW) referrals when the secretary was not available administrative staff had been cross trained so they had the competencies to work within another role during absences. The practice had then undertaken an audit to ensure referrals were in line with the 2WW guidelines.</p> <p>The practice had a medical emergencies policy and a sepsis awareness policy. 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).</p> <p>Administrative staff had received additional training (2017) in 'red flags' such as managing chest pain and the National Early Warning Score (NEWS) for sepsis. At the time of the training the practice had included medical students' attendance on the course.</p>	

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
We reviewed individual patient records and found extensive and careful record keeping in line with best practice guidance.	

Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	0.83	0.91	0.95	Comparable with other practices
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2017 to 30/06/2018) (NHSBSA)	2.9%	4.9%	8.7%	Significant Variation (positive)

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y

If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	Partial
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y
<p>The practice undertook audits in addition to national and local benchmarking audits such as an audit to review patients on blood thinning medicines who were at risk of teratogenicity (risk of a birth defect in pregnant women).</p> <p>One GP undertook the lead role within Somerset Clinical Commissioning Group Prescribing and Medicines Management (PAMM) group, representing West Somerset practices.</p> <p>The practice was rated one out of 78 for the local CCG table for appropriate antibiotic prescribing (2017/18). They currently remain as top for 2018/19.</p> <p>At the branch surgery movement of a Schedule 2 controlled drugs into and out of the practice were not recorded in a recognised controlled drugs (CD) register. Following inspection, the practice confirmed receipt of an approved CD register. At the main site the emergency medicines were in an area where people visiting the practice could gain access to. Following inspection, the practice confirmed they had implemented a tamper proof seal to emergency medicines.</p>	

Dispensing practices only	Y/N
There was a GP responsible for providing effective leadership for the dispensary.	Y
Access to the dispensary was restricted to authorised staff only.	Y
The practice had clear Standard Operating Procedures for their dispensary staff to follow.	Y
The practice had a clear system of monitoring compliance with Standard Operating Procedures.	Y
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on medicines were supplied with the pack.	Y
Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe.	Y
The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability).	Partial
Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians.	Y
<p>Cleaners had supervised access to the dispensary however there was no risk assessment in place. On the day of inspection, a risk assessment was provided.</p> <p>The delivery driver had recently taken on some home deliveries of medicines. They did not have a DBS check completed. Risk assessments were completed during the inspection for medicines collected at remote collection points which required refrigeration and DBS checks. A plan was already in place to provide safeguarding training for the driver.</p> <p>We found the dispensary to be organised and well run.</p>	

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y
Number of events recorded in last 12 months.	15
Number of events that required action	15

Examples of significant events recorded and actions by the practice:

Event	Specific action taken
Local measles outbreak	The practice undertook significant event learning to understand how they could improve on future infectious disease outbreaks. An action was to update the recruitment policy and processes to ensure all new staff had a record of childhood immunisations. And current staff were asked to update their immunisation records and where necessary the practice provided vaccination updates. The practice then had a suspected measles case and undertook a learning from excellence investigation to ensure lessons learnt previously worked well.
There were delays (a locum GP sent a referral to someone on leave) and wrong referrals (an error during the referral process) for two-week wait appointments requests when the secretary was on leave.	Staff covering the role were provided with additional training. GPs were tasked with checking the referral system during staff absence. Access to the system changed, as a safety net, so a deputy could check for referrals sent.
High INR blood test result (A high INR result means blood clots too slowly and risks patients bleeding).	The branch surgery now stocked Vitamin K to enable reversal of a high INR (when indicated by guidelines). Following this event, the practice had another high INR incident when a patient was taking antibiotics which resulted in a change to monitoring processes to ensure more frequent monitoring of blood clotting levels. (Antibiotics can interact with blood thinning medicines to increase blood clots).

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y
Comments on systems in place:	

The practice manager took responsibility for receiving and distributing safety alerts to relevant staff. We found all alerts were logged, ownership and accountability clear and evidence of action taken recorded. The practice was signed up to the NHS England five 'sign up to safety' pledges. (Put safety first, continually learn, honesty, collaborative and support).

Effective

Effective needs assessment, care and treatment

Prescribing				
Indicator	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA)	0.35	0.72	0.84	Variation (positive)

People with long-term conditions

Diabetes Indicators				
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	72.6%	71.9%	79.5%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	2.3% (5)	8.0%	12.4%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	76.6%	68.5%	78.1%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.9% (4)	6.0%	9.3%	

Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2016 to 31/03/2017) (QOF)	70.4%	78.0%	80.1%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	6.6% (14)	10.0%	13.3%	

Other long term conditions				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2016 to 31/03/2017) (QOF)	78.3%	59.2%	76.4%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	2.0% (6)	5.0%	7.7%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	89.2%	68.1%	90.4%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0 (0)	5.9%	11.4%	

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2016 to 31/03/2017) (QOF)	88.7%	76.5%	83.4%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	2.4% (20)	3.4%	4.0%	
Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2016 to 31/03/2017) (QOF)	84.1%	85.3%	88.4%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	3.8% (5)	4.5%	8.2%	

Additional evidence: People with long-term conditions

Patients had access to:

- NHS Healthier You Diabetes Prevention Programme (wearable technologies that monitor levels of exercise, apps which allow users to access health coaches and online peer support groups).
- A NICE-aligned, accredited structured education and behavioural change programme for adults with type 2 diabetes. (The programme provides 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).

Those patients (330) with clinical indicators of prediabetes were given information on reducing blood glucose levels and reviewed by a practice nurse in three months. (Prediabetes is when a patient has warning signs that indicate continued lifestyle could result in diabetes).

Following a national review of asthma deaths one practice nurse undertook an audit to ensure patients with an asthma diagnosis were receiving care in-line with the recommendations from the review. Where necessary patients were called into the practice for a review and treatment changed as per national guidance. Record templates were reviewed and adapted to ensure patients received appropriate and timely referral to secondary care services.

The associate practitioner used medically certified technology to screen patients opportunistically for atrial fibrillation (a common heart rhythm disorder that increases the risk of stroke).

Exception rate reporting for long term conditions was below local and national averages. (Exception reporting is intended to allow practices to “achieve” quality improvement indicators without being penalised for patient specific clinical circumstances or other reasons beyond the practices control).

We saw the exception rating for some conditions indicators were higher than the national average for 2016/17. We reviewed the exception reporting and found adequate rationale for all patient exclusions. For example, exception reporting for patients with osteoporosis was 33.3% (national average 14.5%) however under SPQS practices undertook different quality improvement activity for bone health.

Families, children and young people

Child Immunisation				
Indicator	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017) (NHS England)	24	25	96.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) (NHS England)	31	31	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2016 to 31/03/2017) (NHS England)	31	31	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)	31	31	100.0%	Met 95% WHO based target (significant variation positive)
<p>The practice nurses had written to all patients who at the time of their MMR immunisation were only scheduled for one immunisation. They invited all these patients to return for a booster.</p> <p>One GP, previously employed at the practice, had a special interest in neurodevelopment and the link between emotional, mental and physical health. They ran The Somerset Emotion Coaching Project which the practice referred families to. The project supported children, young people and families with behavioural, emotional and mental health difficulties, many of whom will have experienced significant adversity. Practice staff had received introductory training on emotion coaching along with an introduction to an evidence based parenting programme in emotion coaching 'Tuning into kids' for which the practice manager was trained in.</p>				

Working age people (including those recently retired and students)

Cancer Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	77.1%	74.3%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	76.9%	74.9%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	61.5%	61.2%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)	36.7%	45.3%	71.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	43.2%	55.0%	51.6%	Comparable with other practices
<p>Nurses have appointments available from 8am daily and until 8pm one day per week to encourage cervical smear uptake. After a new practice nurse had difficulty completing her cervical smear training due to a lack of trained nurse assessors the lead nurse undertook assessor training and provided support to nurses across the GP federation.</p> <p>We looked at the most recent QoF data for the current year (2018/19) which showed the practice had achieved 1076 (83%) cervical screening to date. (80% of cervical screening for the practice population equates to 1067 patients).</p> <p>All patients who do not respond to invites for breast and bowel cancer screening received a letter from their named GP discussing the importance of the test and encouraging uptake.</p> <p>The practice was in the process of implementing the Gold Standards Framework (GSF) and was working towards “going for gold accreditation”. Since implementation we saw patients had been reviewed with regards to the best action to take if a patient dies suddenly (DNACPR); a need based coding system for patients nearing end of life and an agenda item at the multi-disciplinary team meeting to discuss these patients. The GSF is a quality improvement programme which is influential in end-of-life care (EOLC).</p>				

People experiencing poor mental health (including people with dementia)

Mental Health Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	53.3%	42.2%	90.3%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	6.3% (1)	6.3%	12.5%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	53.3%	48.1%	90.7%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	6.3% (1)	5.5%	10.3%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	26.9%	35.8%	83.7%	Significant Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	7.1% (2)	5.8%	6.8%	

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

The practice took part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). SPQS measures quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators.

QOF scores showed some negative variations (worse than national averages) for most mental health targets. We saw evidence the practice had raised a concern about the QOF data for 2016/17 (shown above) which we were told was inaccurate due to merging an additional practice list whose patients had been coded incorrectly. We found the practice had reviewed coding for episodes of contact with patients and improved the coding to ensure any contact with patients was appropriately recorded.

We looked at current data for 2018/19 which showed:

- 83% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record. (Target 90%).
- 89% of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded. (Target 90%).
- 77% of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months. (Target 70%).

The GP Trainee was section 12 mental health trained and was due to start a salaried post. One partner trained in psychiatry before general practice and a salaried GP was undertaking a MRCPsych (a postnominal qualification awarded to doctors having who have completed additional training and examination mandated by the Royal College of Psychiatrists).

Dementia:

- The practice had adopted the local clinical commissioning group new dementia pathway which included a process for GPs to diagnose dementia in elderly patients who may not wish to go through the process of diagnosis and tests via the memory service.

The GPs regularly reviewed the patient list of patients with a dementia diagnosis. The Living Better Nurse undertook home visits and reviews.

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	404	413	539
Overall QOF exception reporting (all domains)	2.5%	3.9%	5.7%

Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF)	Y

Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	95.3%	89.8%	95.3%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0.8% (10)	1.0%	0.8%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
<p>The practice obtained consent to care and treatment in line with legislation and guidance. Written consent was obtained for minor surgery procedures, joint injections and cryosurgery with verbal consent for other procedures. All were recorded within patient records with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.</p> <p>We reviewed patient records and saw explicit and in-depth recording around mental capacity assessments and capacity decisions. They had been appropriately coded.</p>

Any additional evidence
<p>The practice embraced social prescribing through their engagement with 'Moor to Enjoy', a national park funded health programme, holding therapeutic storytelling (mindfulness) at the practice to inspire a greater sense of wellbeing and prescribing of books and exercise referral.</p> <p>GPs wrote a regular "Health Bites" article in the Porlock Village magazine, circulated to the whole village, with health promotion advice and updates on contemporary health issues.</p> <p>One GP works with a local school to plan a health week and provide educational sessions. Another GP provided emotional wellbeing sessions for patients.</p>

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	71
Number of CQC comments received which were positive about the service	69
Number of comments cards received which were mixed about the service	1
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
CQC Comment cards:	Patients were unanimous in their feedback stating they were treated with kindness, respect and compassion from all staff, finding them caring and attentive. One mixed review stated that some staff could be warmer than they were.
Practice patient comments log:	<p>The practice held a register of all positive and negative feedback from patients. These were collated through the NHS Friends and Family Test, NHS Choices, verbal and written feedback and dissatisfaction forms. All comments were reviewed by the practice with learning points and changes as a result of the comment recorded.</p> <p>We looked at patient feedback for the past year and saw 16 positive comments such as staff being approachable, helpful and professional and appointments being accessible and timely. There were 12 negative comments such as the use of plastic bags, limited access to alcohol hand gel and not enough toys.</p>

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6211	231	128	55.4%	2.06%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	95.4%	91.5%	89.0%	Comparable with other practices
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern	95.4%	90.2%	87.4%	Comparable with other practices

Indicator	Practice	CCG average	England average	England comparison
(01/01/2018 to 31/03/2018)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	98.7%	97.3%	95.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	97.3%	85.9%	83.8%	Variation (positive)
<p>The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018. The practice continues to receive scores which indicate they are either comparable to other practices or have a positive variation. There is no indication there is a change in patient experience. CQC assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a statistical tool which shows the deviation from the England average. The standard deviation will be different for each indicator which can explain variable differences in our comparison ratings.</p>				

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Date of exercise	Summary of results
October to December 2017	Improved patient access survey: The survey reviewed the current extended hours and Saturday morning surgeries across the GP federation. The conclusion was to continue the extended hours across the area to improve access for the small percentage of patients that used the service.

Any additional evidence
<p>A training session had been provided to staff to introduce them to mindful emotion coaching to build emotional resilience and mental wellbeing. The session aimed to empower staff to have knowledge to enable an empathetic problem-solving approach to patient interactions.</p> <p>Other training included a significant adversity programme to help staff communicate with patients during episodes of challenging behaviours.</p>

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
CQC comment cards:	Patients told us they received a high standard of care, were listened to, information was explained clearly and carefully and they were always involved in decisions about their care and treatment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	98.5%	95.9%	93.5%	Comparable with other practices
Question				Y/N
Interpretation services were available for patients who did not have English as a first language.				Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.				Y
Information leaflets were available in easy read format.				Y
Information about support groups was available on the practice website.				Y

Carers	Narrative
Percentage and number of carers	The practice had identified 322 patients with a carers role which equates to approximately 5% of the practice list.
How the practice supports carers	Both practice sites have a trained carers' champions and had a plan to improve the carers register and provide support for this group. They had been trained to undertake frailty and falls risk assessments. A carers support group was available at one site and another was due to begin the month of inspection. In addition, the carers' champion attended flu clinics and completed a falls risk assessment tool. Bereavement cards are sent to offer support at a potentially vulnerable time. They regularly liaised with the Village Agent service which help to bridge the gap between isolated, excluded, vulnerable people and statutory and/or voluntary organisations.
How the practice supports recently bereaved patients	Bereaved patients received a condolences card and the named GP followed up with a telephone call at an appropriate interval. If necessary they were invited to an appointment with a GP. Any patient who was bereaved had a code to identify them within their patient records. The practice had a bereavement pack in line with NHS England Gold Standard Framework.

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y

	Narrative
Arrangements to ensure confidentiality at the reception desk	The practice provided a private room next to reception to enable patients to speak in confidence if they requested this. Telephone calls were not taken at the reception desk.

Question	Y/N
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	Time
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm (Porlock Medical Centre 8am-1.30pm)
Thursday	8am-6.30pm
Friday	8am-6.30pm

Appointments available	
Dunster Surgery 8:20am-10.40am 3pm-5.30pm	Porlock Medical Centre 8:10am-11am 4pm-5.30pm
<p>Extended hours opening:</p> <p>Pre-bookable appointments (face to face or telephone) were available each evening between 6.30 pm and 8.00 pm (Monday to Friday) or at the weekend on a Saturday morning with one of the practices in West Somerset. On Tuesday evenings these appointments were available at Dunster Surgery.</p> <p>Practice nurse appointments were from 8am.</p> <p>The dispensary opens between 8.30am to 12pm and 2pm to 6pm Monday to Friday. The practice also provided a prescription delivery service to local businesses for patient collection.</p>	

Home visits	Y/N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Y
If yes, describe how this was done	
<p>Receptionists had received training to assess any possible "red flags" when a patient requested a visit. Any urgent visit requests are triaged by the duty doctor or added to the emergency telephone list. The home visit requests are discussed mid-morning and GPs share the visits across the practices including residential and nursing homes. We saw GPs were willing to carry out home visits after surgery.</p>	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6211	231	128	55.4%	2.06%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	99.3%	95.8%	94.8%	Variation (positive)

Timely access to the service

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	98.4%	74.4%	70.3%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	96.2%	70.9%	68.6%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	92.5%	67.0%	65.9%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	96.7%	78.2%	74.4%	Significant Variation (positive)
CQC assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a statistical tool which shows the deviation from the England average. The standard deviation will be different for each indicator which can explain variable differences in our comparison ratings.				

Examples of feedback received from patients:

Source	Feedback
CQC comment cards:	Patients were positive about access to the practice and appointments.
NHS Friends and Family test:	Of the 122 patients asked if they were likely to recommend the practice to family and friends 106 were extremely likely, 6 likely, 9 neither likely or unlikely and one don't know. The main reasons for choosing those options were: 51% had a level of confidence in the clinician and 42% the support provided by staff. (January to August 2018)
Facebook	The practice provided information around feedback provided by patients on a Facebook local conversation group in response to a request for GP recommendations. We saw two posts which generated 84 out of 88 respondents to recommend the surgery. Feedback included: since changing to the practice I am being taken seriously; staff understand and empathise and it was like being a private patient due to the care provided.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	8
Number of complaints we examined	3
Number of complaints we examined that were satisfactorily handled in a timely way	8
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0
Additional comments:	
<p>The practice manager had undertaken a complaint handling course. We saw the log included a good summary of learning points and a review cycle for each complaint. For example, following any actions taken the practice added a date for the complaint and actions to be reviewed to demonstrate actions had been embedded into practice and no further action was required.</p> <p>We also looked at the negative comments log and four incidents. We saw the practice manager reviewed these, recorded evidence of lessons learnt and actions put in place. These were discussed at the regular administration meeting.</p> <p>When a complaint was raised around a locum GP, the practice provided protected time to allow them to respond to the complaint.</p>	
Example of how quality has improved in response to complaints	
<ul style="list-style-type: none"> Following a cancer diagnosis, a patient did not return for a follow-up appointment. The practice put a process in place to ensure required follow-ups were recorded in the patient records and in the administrative tasks section of the IT system. An audit was undertaken to ensure compliance with practice policy. Following an incident when blood test results were not communicated appropriately, a process was set up to ensure any administrative tasks not completed were carried forward to the next day. When tasks were completed a 'striethrough' was added. 	

- After a member of staff made a perceived discriminatory comment staff received additional equality & diversity training and LGBT (lesbian, gay, bisexual, and transgender) training.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice

The practice had a focus to drive and improve the delivery of high-quality person-centred care:

- All partners had external leadership roles such as NHS England patient safety lead for clinician's performance, practice and conduct; director of clinical governance for a Somerset GP organisation which looks to ensure high quality NHS care is maintained and Somerset Clinical Commissioning Group representative for prescribing and medicines management.
- The practice manager had undertaken an improvement fundamentals course (a plan-do-study-act (PDSA) method) as well as a management development course. One partner was undertaking a clinical leadership course.
- Following the merger of three practices the practice manager implemented workflow optimisation. By upskilling two receptionists to provide a centralised administrative hub they reduced time clinicians spent on administrative tasks. The team took part in regular audit and clinical oversight which demonstrated staff competency and improved management of clinical processes through accomplishment of tasks.
- Since the merger of the practices the practice had 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.
- 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.
- Training was provided to develop skills and capabilities within the practice team. For example, a health care assistant had undertaken associate practitioner training (two-year foundation degree aligned with the sustainability and transformation partnership (STP), the practice and higher education) to enable them to move away from a task-based role, and towards a role that is more patient and outcomes-focused.

Vision and strategy

Practice Vision and values

Following the merger of three practices staff had worked as a team to develop a practice vision: A happy, well supported, high achieving workforce who are empowered to provide exceptional care.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care

- Staff attend (mindful) emotion coaching training to enable effective communication with vulnerable patients, empower staff to show empathy and respond effectively to difficult situations and to provide them with workplace resilience.
- The practice manager is a trained wellness coach and had cascaded this training to staff as well as staff from other local practices.

- Free online or face to face counselling was made available. Personal emotional coaching sessions were provided to staff by a GP who ran the Somerset Emotion Coaching Project.
- The practice was a training practice for medical students and trainee GPs. They had been rated as outstanding by the local deanery for their trainee GP training. GPs mentored district nurses through their nurse prescribing course.
- The practice was a RCGP Sentinel practice. This meant it worked with the Research and Surveillance Centre (RSC) to share data, provide a picture of their workload and complexity of cases and be involved in research projects to improve patient outcomes.
- The most recent Score survey results (August 2018) showed improvements in teamwork (up 35%); work-life balance (up by 24%) and leadership (up by 22%) following the first survey (2016).
- One GP had a pastoral care lead role for NHS England. The practice had supported a GP to return to work through this process.
- The practice was in the process of implementing and “going for gold accreditation” for the Gold Standards Framework a quality improvement programme which is influential in end-of-life care.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
CQC staff questionnaires	During inspection we received 18 completed questionnaires from staff including receptionists, dispensers, secretaries, department managers and nurses. Staff told us they were listened to, such as when dispensary staff requested a two-hour daily closure so they could have uninterrupted time to complete medicine requests; had opportunities to discuss complaints and significant events and input ideas for improvements they felt supported and respected and they were proud to work at the practice.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	Clinical governance policy (including clinical audit, lead areas of responsibility for nursing staff, clinical effectiveness and research & development.
Other examples	The practice was in the process of “going for gold accreditation” for the Gold Standards Framework (GSF).
	Y/N
Staff were able to describe the governance arrangements	Y
Staff were clear on their roles and responsibilities	Y

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place	Y
Staff trained in preparation for major incident	Y

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Patients with Hickman lines had to travel to a local hospital when blocked or faulty.	The practice arranged training for a practice nurse on ICC/Hickman Lines (usually used for patients receiving chemotherapy) was an improvement to service that arose directly from a suggestion by a patient. This had an impact in improving support and reducing travel for patients.
Medical Protection Society clinical risk assessment of practice	<p>The practice undertook a clinical risk assessment to ensure they complied with national standards around the quality of care and patient / staff safety. The risk assessment was a whole team approach to work together, talk openly and develop practical solutions that promote safer practice. To reduce risks an action plan of 49 identified risks was implemented leading to 100% risk reduction in identified risks. For example:</p> <ul style="list-style-type: none"> • A protocol to follow-up patients who do not attend appointments or respond to invitations at the practice, hospitals and community mental health services. • Eye testing for staff using a VDU (in accordance with Display Screen Awareness Regulations). • Improving confidentiality at reception desk by phone calls answered away from the desk, test results only provided at certain times, patients waiting for dispensed medicines to wait away from the area. • A programme to review and update all practice policies. • An audit to review recording of home visits in patient records. • Female GP due maternity leave so female locum GPs booked

	<p>weekly in the practice.</p> <ul style="list-style-type: none"> • An annual infection control statement produced by practice. • Incident policy reviewed in line with Duty of Candour and relevant legislation.
SCORE	<p>Following the merger of three practices two Score surveys have been carried out. The Score survey measures important dimensions of organisational culture and integrates safety and teamwork culture, local leadership, learning systems, resilience and work-life balance. By improving culture evidence suggests care and treatment (safety) is improved. It has been used by the practice to implement improvements such as protected time for dispensary staff, upskilling, improved access and system for mandatory training, whole practice reviews and learning around significant incidents and a representative from each practice area at multi-disciplinary meetings.</p>

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback

The patient participation group (PPG) met quarterly and standing agenda items included a practice report presented by practice staff to update the group on staffing levels and changes, key activities, performance and future planning. They told us:

- The PPG had received no evidence that there were specific groups in the patient population that were being underserved.
- The leadership team demonstrated their openness in reports made to the PPG and in the discussions at PPG meetings. There was a good relationship with those practice representatives and the practice was willing to share problems and discuss issues whilst respecting the duty of PPG members to raise concerns and question policies and procedures from a patient viewpoint. Discussions are invariably constructive and aimed at continuous improvement of services.
- The regular reports to PPG meetings from the practice leaders reflected the attention they paid to what was being fed back from patients day-by-day as well as the results of occasional targeted enquiries.
- The practice had a patient suggestion box and all patient comments were shared with the PPG.
- The PPG also had a contact option on the practice website where patients can provide feedback and suggestions.
- In 2017 the practice piloted a therapeutic storytelling group. Following positive patient feedback, the PPG enabled the continuation of the group and provided funding through the 'friends of' charity. They have extended invitation to any patient within the West Somerset GP federation. The practice had included a wellbeing scale to enable the monitoring of mental wellbeing in attendees and to evaluate the project.
- A quarterly practice newsletter was available at the surgeries and distributed with repeat prescriptions. (The PPG help to shape the content of each newsletter and propose specific items during discussions at the PPG Meetings).

Any additional evidence

Fundraising is carried out separately by the two 'Friends' charitable groups. The Friends of Porlock have access to resources boosted by an annual legacy from a former patient's family. These funds have been used in the recent past to help support developmental work in the surgery such as funding a community nurse practitioner as part of the pilot work for the 'Living Better' project; nightsitters for end of life care (including all residents across the GP federation); emotional resistance training and for storytelling workshops.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Record keeping audit.	2-cycle audit following a patient complaint which resulted in significant event analysis. An audit was undertaken to review 12 aspects of recording of clinician notes within patient records to ensure they were acceptable within NHS England criteria and GMC and RCGP best practice. The re-audit showed significant improvement in the areas of weakness previously highlighted: the number of consultations where there was adequate documentation of relevant negative features in the history and examination had improved from 29% to 79%; Relevant clinical examination findings had been documented much more thoroughly with an improvement from 45% to 94%; Advice for common side effects/interactions improved from zero to 75% and Safety netting improved from 43% to 94%.
After death analysis audit.	2-cycle audit assessing the care provided to the patient at end of life such as advanced care plans in place, identified carers, symptom assessment tools and discussion at palliative care meetings. Points identified and improvements being implemented. The audit identified several weak areas in the provision of end of life care which led to the practice developing strategies to improve. For example, they now use a form during monthly palliative care meetings to check off each aspect of care which may be required and the Going for Gold accreditation helped them look at these areas in more detail.
Long term nitrofurantoin safety audit	2-cycle audit for the use of long term (prophylactic) nitrofurantoin (a medicine used to treat urinary tract infections) is associated with a risk of two serious complications. The audit followed a medico-legal case in England and was instigated as part of the MPS clinical risk assessment learning. As a result, patients were reviewed by a GP with a view to ongoing appropriateness and necessity of the medicine.
Monitoring for women with a history of gestational diabetes	As a result of the audit the practice changed protocols to ensure these patients undertook annual blood glucose monitoring due to the risk of them developing diabetes.

Any additional evidence
<ul style="list-style-type: none"> • The practice previously implemented and funded a pilot for a living better nurse in partnership with local healthcare, social services and charities. Since our last inspection the pilot had received NHS funding for three years and had been rolled out to other practices across the GP federation. The service has led to practices and other healthcare services collaboratively working together and has led to improved social networks and care provision for patients. The practice continually evaluates the project and as a result have sought further funding from the 'friends of' charity to extend the scope beyond what the funded service provides. • 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.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	Comparable to other practices	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment. ([See NHS Choices for more details](#)).