

Care Quality Commission

Inspection Evidence Table

Summervale Surgery (1-545738112)

Inspection date: 26 February 2020

Date of data download: 07 February 2020

Following our comprehensive inspection at Summervale Surgery (7 August 2019) the location was rated as inadequate with an inadequate rating for safe, effective and well-led and a good rating for caring and responsive. Following this inspection we placed the service into special measures. The serious concerns were such that we took further steps to ensure the provider made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices of 23 August 2019.

We issued warning notices in regard to:

- Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance
- Regulation 18(2) of the Health and Social Care Act (Regulated Activity) Regulations 2014, Staffing.
- Regulation 19(1)(2)(3) of the Health and Social Care Act (Regulated Activity) Regulations 2014, Fit and proper persons employed.

A focused follow up inspection was undertaken on the 27 November 2019 to check the progress the provider was making in regard to the regulatory breaches set out within the warning notices. At this inspection we found significant steps had been taken to address the identified areas of concern. We told the provider there were areas of the service where they needed to make improvements. We issued requirement notices which required the provider to:

- Ensure patients are protected from abuse and improper treatment
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

There were areas identified where the provider should consider actions:

- Continue to review and update where necessary risks assessments relating to health and safety at work. For example, the actions from the fire risk assessment.
- Complete annual appraisals for all staff in line with practice policy.
- Continue to review and update staff files in line with NHS guidance.
- Consider processes to identify vulnerable patients such as people living with dementia, veterans and bereaved families.
- Continue to take action to improve emergency admission rates and admission rates to hospital due to respiratory concerns.
- Continue to embed clinical supervision for clinical staff including a formal system to document non-medical prescriber competencies.

- Continue to work towards completion of staff appraisals in line with practice policy.

This inspection, undertaken on the 26 February 2020, was held to review the progress the provider had made in relation to the overall rating of Inadequate and the changes made as a result of previous requirement notices.

Overall rating: Good

Since our previous inspections in August 2019 where we rated the practice as Inadequate and the November 2019 to follow-up on actions taken to address the significant risks, we found there had been significant and embedded positive changes and we have rated the practice as Good overall.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Good

In August 2019 we rated the provider as inadequate for safe as we found the practice did not have clear systems and processes to manage risks and protect people from harm. At this inspection, we found the practice had taken appropriate actions to ensure systems and processes were safe and in line with national guidance.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
In November 2019, as a result of warning notices we carried out an inspection to review progress the provider had made around our identified concerns with regards to the practice having clear systems and	

Safeguarding	Y/N/Partial
<p>processes to keep patients safe. At that inspection we found significant progress had been made to ensure there was appropriate governance of safe systems in regard to safeguarding. However we found:</p> <ul style="list-style-type: none"> • Actions were required to ensure all clinical staff had access to meeting records and patient records consistently recorded safeguarding concerns. • Completion of the practices statutory training had progressed however gaps remained including, level three safeguarding adults and children training and e-learning for FGM (female genital mutilation). <p>At this inspection we found the practice had:</p> <ul style="list-style-type: none"> • Bi-monthly safeguarding meetings with external organisations. We spoke to health visitor and district nursing teams who were positive about their experiences when concerns of abuse were raised with the practice. • A meeting with the clinical commissioning group (CCG) designated nurse for safeguarding was planned to review the new systems and processes to support patients at risk of or experiencing abuse. • Information to support and direct staff what to do if they had a concern were visible. Staff we spoke to understood the importance of raising concerns and were familiar with processes they should take. • We reviewed the 12 patient records relating to children at risk of harm. We found two records did not have alerts to identify the risk to clinicians. During inspection this was remedied. • We reviewed eight of the 29 vulnerable adult patients and those who were veterans. We found three required an alert on the system which were remedied during our visit. • Following our inspection the practice reviewed their safeguarding policy, providing clear guidance on processes staff must take following identification of a concern. This included an alert on the patient records. • At the time of inspection patients living with a learning disability were being reviewed to ensure the appropriate coding and alerts were within patient records. Following inspection, we had confirmation these had been completed. 	

Recruitment systems	Y/N/Partial
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 if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Following our inspection in November 2019 the practice had reviewed recruitment procedures and staff files. We found:</p> <ul style="list-style-type: none"> • An up to date recruitment policy was in place and information was reflected within the staff handbook. • There were effective recruitment and monitoring processes in place. For existing staff where there had previously been omissions, information had been obtained where possible. Where this was not available the appropriate risk assessments had been undertaken. For example, proof of vaccination status against infectious disease, evidence of staff qualifications and a pre-employment checklist. 	

- There was an overarching system to review clinical staff revalidation or professional registration renewal had taken place.
- An effective employee immunisation programme was in place.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: May 2019	Y
There was a record of equipment calibration. Date of last calibration: February 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: January 2020	Y
There was a log of fire drills. Date of last drill: February 2020	Y
There was a record of fire alarm checks. Date of last check: Weekly	Y
There was a record of fire training for staff.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2019	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Previously (November 2019) we saw the practice had taken action through development of an action plan and timescales to complete omissions. We could see progress against identified risks had been taken with the exception of fire training, where five members of staff had not yet completed the practice's mandatory e-learning.</p> <p>At this inspection we found:</p> <ul style="list-style-type: none"> • An asset register was in place and the practice could demonstrate all clinical equipment had undergone necessary calibration and service. • The practice had a working action plan to ensure appropriate and necessary safety checks were in place. This included actions from the fire risk assessment (January 2019) • Where actions were in progress, in relation to the management of legionella and electrical wiring actions the practice was working with the neighboring practice and the building owner to resolve these. Risk assessments were in place alongside regular measures to reduce risk. For example, whilst awaiting a new boiler the practice had tap filters in place and a process to change these bi-monthly. • Actions from the previous fire risk assessment had been completed with the exception of three low risk actions. For example, one room required vents in the door. We saw a dated plan was in place to implement the change. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Monthly	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Monthly	Y
<p>At our inspection in August 2019 we found an operational system to manage, regularly assess and monitor risk to safety was not in place. This included a named health and safety lead; a system of regular safety monitoring checks; documentation to support a five-year electrical wiring inspection and test; an absence of workplace risk assessments in relation to COSHH (Control of substances harmful to health), liquid Nitrogen and Oxygen. The practice had addressed these risks when we visited in November 2019, however a full evaluation of the safety of the premises was ongoing at the time of our inspection.</p> <p>During this inspection we reviewed progress made against previous actions. We found:</p> <ul style="list-style-type: none"> • The practice had implemented monthly health and safety monitoring. • Appropriate risk assessments were in place. For example, an assessment of risk due to potentially slippery pathways. • An electrical wiring inspection had been completed. • The practice had appointed a health and safety lead who had previously completed appropriate training and was booked into a refresher course. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Previously (August 2019) the infection, prevention and control audit (IPC) was not dated or signed. The audit contained a lack of detail and despite identifying risks an action plan to take action was not in place. We found the practice had failed to notify us of a legionella risk within the practice and the practice was unable to demonstrate effective control measures were in place.</p> <p>In November 2019, the practice was able to demonstrate they had taken action to address our concerns including the appointment of a new IPC lead who had completed a number of audits and implemented actions as a result.</p> <p>At this inspection we reviewed the systems and processes for infection prevention and control and found these to be safe and in line with national guidance.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<ul style="list-style-type: none">• Clinical meetings included patient case reviews of hospital admissions, patient deaths and urgent referrals.• The induction policy and new starter pack had been reviewed.• The locum pack for clinical staff had been updated.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	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
<p>During our previous inspection (August 2019), staff told us there was a backlog of patient referrals to secondary care and the process did not prioritise urgent referrals. A process to audit the system regularly to ensure that it is functioning effectively did not take place and staff told us they felt they were unable to voice concerns around the effectiveness of the system. In November 2019 we reviewed the management of referrals and found the practice had taken action to address the issues.</p> <p>At this inspection, we spoke to staff and checked the system for referrals. We found no outstanding urgent referrals. Non-urgent referrals, awaiting process, were from the day of inspection. Staff told us there had been considerable improvement and they no longer felt unable to manage the process.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.88	0.85	0.87	No statistical variation
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). (01/10/2018 to 30/09/2019) (NHSBSA)	5.7%	4.7%	8.5%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	6.18	5.99	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.77	2.38	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use 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, investigation of 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 appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p data-bbox="57 1122 1541 1310">In August 2019 we found concerns in terms of the management of emergency medicines and administration of medicines documents, Patient Group Directives (PGDs). In November 2019 we reviewed the concerns and found the practice had taken action to resolve these. This included improved secure storage of medicines such as Oxygen; processes to ensure emergency equipment was fit for use and PGDs updated to reflect current staff only.</p> <p data-bbox="57 1355 1541 1433">At this inspection we reviewed these processes and found they were satisfactory. We also found improvements in the safety of medicines management:</p> <ul data-bbox="105 1444 1541 1738" style="list-style-type: none"> <li data-bbox="105 1444 1541 1556">• There was a formal system in place to review the prescribing competence of the non-medical nurse prescribers. Some patient reviews had taken place at clinical meetings including cases where the nurses had prescribed medicines (in line with prescribing medicines guidance). <li data-bbox="105 1556 1541 1738">• The practice was able to demonstrate through the clinical commissioning group (CCG) scorecard for medicines management positive prescribing trends. Areas outside of target had actions in place to improve prescribing and/or the practice had undertaken audits within these areas. For example, reviewing prescribed inhaler medicines for respiratory patients and, an audit on the reduction of use of urine testing within the practice. 	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	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.	Partial
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Partial
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>At our inspection in August 2019 we found the Standard Operating Procedure (SOP) was not fully up to date. Dispensary staff could demonstrate they had taken action to record changes in writing within the document however there was a risk of staff not taking action in line with the changes. This was rectified by our inspection in November 2019.</p> <p>At this inspection:</p> <ul style="list-style-type: none"> • The practice had recruited additional staff for the dispensary. • The SOP for controlled medicines was not being fully followed. We saw the document advised that whenever possible two dispensers should undertake stock checks for controlled medicines. This was not taking place and we highlighted the risk to the practice. During inspection the SOP was amended, and staff advised that two dispensers should always complete the process. • The SOP did not contain guidance for monitored dosage systems. This was updated within the SOP during our inspection and an information leaflet was provided to patients. • The practice had risk assessments for the delivery service. However, at the time of inspection, risk assessments for the locations holding patient medicines for collection had not been assessed. Following inspection the practice provided risk assessments for the locations. No concerns had been identified at the time of completion. • A risk assessment was not in place in terms of the collection of on the day acute medicines where a prescription had not been signed by a GP. Following inspection we received a risk assessment. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and 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:	20
Number of events that required action:	20
<p>Previously (November 2019) we found the practice had taken steps to improve the management of incidents including significant events. A system had been introduced to discuss significant events at practice meetings.</p> <p>At this inspection we found:</p> <ul style="list-style-type: none"> The practice had reviewed all incidents since our inspection in August 2019 for themes and trends. Staff were able to discuss these in detail however an overarching document for easy access to these was not available. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A pharmacy had received a repeat prescription without the required medicine.	<ul style="list-style-type: none"> The practice generated another prescription with the correct medicines. Staff managing repeat medicine requests were advised of the issue and the need for cross checking with repeat medicines. The issue was added to the practice meeting for discussion
Review of a patient death following an assessment by a member of the clinical team.	<ul style="list-style-type: none"> An action was taken to ensure members of the clinical team not employed by the practice were reminded to record risk of sepsis scores within patient records.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
We reviewed the management of safety alerts which the practice had implemented since our inspection in August 2019. We found the changes implemented by November 2019 were fully embedded.	

Effective

Rating: Good

In August 2019 we rated the provider as inadequate for effective because the practice was unable to demonstrate staff had the skills, knowledge and experience to carry out their roles and monitoring of the quality of care provided was limited. At this inspection we reviewed the changes implemented by the previous inspection (November 2019) and found these to be embedded.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
<p>Following our August 2019 inspection the practice had implemented to changes to address our concerns.</p> <p>Until April 2019 the practice had taken 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 measured quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators. Under the SPQS framework reporting on some indicators such as the QOF data below, which showed a negative variation were not included meaning the negative variation in achievement shown were not always representative.</p> <p>However we raised concerns with the practice because information obtained at the inspection (August 2019) had demonstrated areas for improvement:</p> <ul style="list-style-type: none"> • An action plan in regard to managing areas of concern and low QOF data was not in place. • Due to staff leaving employment there were gaps in the timeliness of reviews. Up to date data for patients with long-term conditions (LTC) whose reviews were outstanding was not available. • Staff undertaking tasks such as coding within the system had not received any updated training since re-joining the scheme. 	

- Locum nurses were undertaking LTC reviews and there was not a process to ensure they were documenting necessary information within the patient record.

In November 2019, during our visit, the practice had demonstrated improvements in this area including improvement in the patient record system and the coding of patient conditions; improvement in QOF targets including evidence to show annual reviews for respiratory patients had been undertaken; improvement in data for emergency admissions and admissions to hospital due to respiratory concerns. The GPs were able to demonstrate they had an action plan in place and were focusing on specific areas such as frailty, to ensure patients were receiving appropriate care and treatment.

At this inspection we found the practice had worked to address the effectiveness of care and treatment provided:

- A health care assistant had been employed and was undertaking diabetic foot checks.
- An additional practice nurse with appropriate qualifications for long-term condition management was due to commence employment. They had been working at the practice as a locum nurse.
- There was protected time for the nurse practitioner to review respiratory patient records.
- The local medical committee (LMC) had provided staff resource and support to manage improvements in QOF data.
- The practice continued to meet the changes required within their action plan.
- There were clear clinical pathways with supporting systems and processes to meet people's needs.

Prescribing	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) (01/10/2018 to 30/09/2019) (NHSBSA)	0.29	0.64	0.74	Variation (positive)

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice followed up patients who had received treatment in hospital or from out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	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 (01/04/2018 to 31/03/2019) (QOF)	68.0%	70.1%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.0% (9)	8.0%	12.8%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	56.8%	68.5%	78.1%	Variation (negative)
Exception rate (number of exceptions).	2.9% (13)	6.8%	9.4%	N/A
	Practice	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 (01/04/2018 to 31/03/2019) (QOF)	71.8%	76.4%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	10.8% (49)	11.1%	12.7%	N/A

Other long-term conditions	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 (01/04/2018 to 31/03/2019) (QOF)	56.0%	63.5%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	1.2% (6)	6.7%	7.4%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	45.4%	74.1%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	1.6% (3)	8.1%	11.2%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	69.4%	78.2%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	2.8% (42)	3.7%	4.0%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	89.6%	88.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.7% (9)	5.0%	5.9%	N/A

Any additional evidence or comments

During inspection we reviewed data from April 2019 (when the practice re-entered the QOF scheme) through to the day of inspection. Although the data was unverified, we saw the practice had reviewed patients with long-term conditions and were able to demonstrate improvements. In some areas, the practice remained below target at the time of inspection.

- The practice had recently recruited a nurse with a specialty in diabetes.
- Clinical leads for long-term conditions were in place and an action plan supported the practice to work towards national targets.

QOF data April 2019 to present day:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less indicator had changed in 2019. We reviewed the most recent indicator for diabetes (diabetes without frailty and a HbA1c is 58 or less) which was 59%. We saw this had increased from 56% in January 2020 although remained outside of the 75% target.

- Diabetic patients with frailty and a HbA1C of 75 or less was 88% (target 92%). (HbA1C is an average reading of blood glucose levels. High blood glucose levels can lead to medical complications).
- For asthmatic patients in the 2019/20 QOF year, 75% had had an asthma review (target 70%) and 98% (target 80%) had had reversibility testing. (reversibility testing is a measure of lung function in response to medicines).
- The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness was 93% (target 90%).
- The QOF indicator for the percentage of patients with a measured blood pressure had changed from the 2018/19 indicator. For patients under the age of 79 years whom the last BP measured 140/90 was 73% (target 77%). Patients over 80 with a BP measuring 150/90 was 92% (target 86%).

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for three of four childhood immunisation uptake indicators. For one indicator they had met the WHO based national target of 95% (the recommended standard for achieving herd immunity).
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	76	79	96.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	81	86	94.2%	Met 90% minimum

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) (01/04/2018 to 31/03/2019) (NHS England)	81	86	94.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	79	86	91.9%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	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). (01/07/2019 to 30/09/2019) (Public Health England)	79.8%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	77.9%	71.7%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	63.6%	61.4%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	7.8%	45.6%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a	58.9%	56.6%	53.8%	No statistical variation

two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)				
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Any additional evidence or comments

We reviewed the most recent QOF data (April 2019 to present day) which showed:

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period aged 25 to 49 was 82% and patients aged 50 and over was 81%.
- 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 was 98%

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	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 (01/04/2018 to 31/03/2019) (QOF)	3.6%	51.5%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	9.8%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	28.3%	55.4%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	3.6% (2)	8.5%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	65.4%	61.6%	83.6%	Tending towards variation (negative)
Exception rate (number of exceptions).	7.1% (4)	6.4%	6.7%	N/A

Any additional evidence or comments

We reviewed the QOF data from April 2019 to the present day (unverified data) which showed significant improvements:

- 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 was 75% (target was 90% which related to eight patients).
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 73% (target 70%).
- New mental health indicators for 2019/20 showed 84% of patients within this group had a recorded blood pressure (target 90%) and 95% had a recorded body mass index (BMI) (target 90%). The practice had an action plan in place to update patient records before the end of the QOF year. For example, updating during contact for other reasons or by telephoning patients.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	355.5	441.3	539.2
Overall QOF score (as a percentage of maximum)	63.6%	78.9%	96.7%
Overall QOF exception reporting (all domains)	2.1%	4.2%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Any additional evidence or comments
<ul style="list-style-type: none"> The practice had undertaken quality improvement and audit work through the Somerset Practices Quality Scheme (SPQS). An action plan to assist the practice in meeting the indicators necessary for them to demonstrate the care and treatment provided was in line with national targets (QOF) was in place. An annual clinical audit plan was not yet in place. However, the practice had a document to show audit results and actions taken such as a repeat audit. They could demonstrate audits undertaken since our previous inspection in November 2019 and two-cycle audits were demonstrated. We saw clinical audits were discussed at the practice clinical meetings.

Effective staffing

The practice was able to demonstrate staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Previously in August 2019, the practice was unable to demonstrate systems and processes were in place to ensure staff had the appropriate skills and knowledge and, support in place to demonstrate effective staffing. In November 2019 we saw:</p> <ul style="list-style-type: none"> • Role based competencies were in the process of being developed for non-clinical staff. There were competencies in place for all nursing staff. • We saw evidence specific role based training was planned for the nursing team. For example, diabetic and asthma training for health care assistants. • A structure for clinical supervision had been implemented however this was not yet fully embedded. The practice was able to demonstrate monthly meetings had started to take place. • Professional registration checks including evidence of staff revalidation was in place. • There was a process in place to commence staff appraisals. • The practice could demonstrate improvements in training for staff. However, not all staff had completed the training programme and there was no overarching document which demonstrated that all staff had received the correct training for their role. <p>At this inspection we found the practice had continued to review their systems and processes that demonstrated effective staffing:</p> <ul style="list-style-type: none"> • Clinical supervision was in place for the 2 GP retainers. (GP retainers are qualified GPs who require some additional packages of support). • A process was in place to review patient records when patients saw a nurse prescriber or allied health professionals. For example, the emergency care practitioner within the GP federation who undertook home visits. GPs had regular discussions with staff who were non-medical prescribers to review their medicine prescribing. • A face to face clinical review of the competencies of the advanced nurse practitioner was due to take place. We saw there was an appropriate competency checklist. • Staff appraisals had mostly been completed. Those staff with whom an appraisal had not been completed had either a date arranged or were within their induction period. • Staff told us they had been given time to complete staff training via the e-learning system. Training requiring face to face, such as basic life support and sepsis, had been completed. With the exception of new starters the practice had ensured staff had received training in line with their mandatory training policy. • An overarching training document had been implemented and was up to date at the time of inspection. 	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centered care when they moved between services.	Y
<ul style="list-style-type: none"> We spoke to external nursing staff from community services who told us GPs were accessible to discuss patient concerns outside of planned meetings and acted swiftly to resolve issues. They felt involved in the planning and delivery of care and treatment. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<ul style="list-style-type: none"> A walking group was available. Patients were referred to the village agent for additional support and direction. (Village agents is a local service with individuals trained to bridge the gap between voluntary and statutory organisations. They help people find resources to support their needs). 	

Smoking 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 (01/04/2018 to 31/03/2019) (QOF)	81.6%	89.8%	95.0%	Significant Variation (negative)
Exception rate (number of exceptions).	0.5% (11)	1.1%	0.8%	N/A

Any additional evidence or comments

We reviewed the QOF (Quality and Outcomes Framework) smoking data from April 2019 through to the day of inspection:

- 91% of patients with a chronic disease diagnosis had a record of smoking status (target 90%).

- 82% of current smokers had been offered advice to stop. (Target 96% which equated to nine patients not yet receiving advice).

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
<ul style="list-style-type: none"> We spoke to nine patients who told us they were treated with kindness. 	

CQC comments cards	
Total comments cards received.	11
Number of CQC comments received which were positive about the service.	10
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comment cards	Patients told us: <ul style="list-style-type: none"> Staff were approachable and easy to talk to. The service was quick and efficient.
Patients on the day of inspection	Patients told us: <ul style="list-style-type: none"> Staff listened and were caring, compassionate and considerate.
Patient participation group (PPG)	The PPG told us: <ul style="list-style-type: none"> They hear positive feedback from patients Staff are courteous.

National GP Survey results

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 (01/01/2019 to 31/03/2019)	93.4%	91.7%	88.9%	No statistical variation
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 (01/01/2019 to 31/03/2019)	91.9%	90.6%	87.4%	No statistical variation
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 (01/01/2019 to 31/03/2019)	99.3%	96.9%	95.5%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	89.4%	85.4%	82.9%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> The practice carried out patient feedback in the form of the Friends and Family Test. A record of patient comments was kept and reviewed. We reviewed these comments and found positive feedback about experiences of care. GPs undertook individual patient feedback as part of their revalidation.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

- We observed positive interactions by clinical staff.
- Staff signposted patients to the village agent service for support and direction.
- Easy read and pictorial materials were available.

Source	Feedback
Interviews with patients and CQC comment cards.	<ul style="list-style-type: none"> • Staff involved them in decisions about their care. • All patients described the care they received as amazing or excellent.

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 (01/01/2019 to 31/03/2019)	96.9%	95.4%	93.4%	No statistical variation

	Y/N/Partial
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 other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	215 carers had been identified (3% of the practice population).
How the practice supported carers (including young carers).	<p>Previously (August 2017) the practice had identified less than one percent of the practice population as carers. Since this inspection the practice had:</p> <ul style="list-style-type: none"> • Reviewed the practice population and had worked to identify additional patients with a carer's responsibility. • The practice had new processes to identify carers. For example, a message on the appointment check-in screen and information in the new registered patient pack. • The practice facilitated an independent carers support group at the practice. • An additional member of staff had been identified to undertake training for a carers champion role. There was a plan in place to ensure carers champions had allocated time to focus on this role.

	<ul style="list-style-type: none"> Staff helped patients and their carers find further information and access community and advocacy services.
How the practice supported recently bereaved patients.	<p>Previously (August 2019) we found the practice did not have a register of bereaved families and any subsequent support or action taken.</p> <p>The practice now had a process for all staff to follow after a patient death. This included a code of the record of family members and an action log to ensure family and carers received a letter and call from a GP.</p>

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
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
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<ul style="list-style-type: none"> The practice hosted an acupuncturist and the Citizens Advice Bureau. Minor surgery for skin problems was provided. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 to 20:00
Tuesday	08:00 to 18:30
Wednesday	08:00 to 18:30
Thursday	08:00 to 18:30
Friday	08:00 to 18:30
Appointments available:	
Monday	09:00 to 12:45 15:00 to 19:30
Tuesday	09:00 to 12:45 15:00 to 18:00 18:00 to 18:30 (emergencies)
Wednesday	09:00 to 12:45 15:00 to 18:00 18:00 to 18:30 (emergencies)
Thursday	09:00 to 12:45 15:00 to 18:00 18:00 to 18:30 (emergencies)
Friday	09:00 to 12:45 15:00 to 18:00 18:00 to 18:30 (emergencies)

National GP Survey results

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 (01/01/2019 to 31/03/2019)	96.5%	95.6%	94.5%	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> • All patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice provided effective care coordination to enable older patients to access appropriate services. • There was a medicines delivery service for housebound patients. • Home visits were coordinated through the local GP federation. This meant patients in need of urgent care could receive a visit by a paramedic in the morning.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> • Patients with multiple conditions had their needs reviewed in one appointment. • The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. • The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues. • Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings
<ul style="list-style-type: none"> • Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school. • We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm on a Monday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a local GP network to provide an enhanced hours service.
- The practice had an online booking system.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Since our inspection in August 2019 the practice had recruited a new nursing team. They had utilised a regular locum practice nurse to ensure access for patients with long-term conditions until the new nursing team were fully embedded.	

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 (01/01/2019 to 31/03/2019)	89.0%	N/A	68.3%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	72.8%	70.9%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	53.7%	66.3%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	75.5%	77.5%	73.6%	No statistical variation

Source	Feedback
Patient feedback	<p>We gathered feedback during our inspection through completion of CQC comment cards and discussions with nine patients. They told us:</p> <ul style="list-style-type: none"> • It could be difficult to have an appointment with their named GP however they were always offered alternative appointments with other clinicians. • Some patients told us they sometimes waited up to three weeks for a routine appointment. • Patients easily got through to the practice by phone and were always offered an on the day appointment for urgent concerns.

	We also reviewed feedback left on intranet sites. We found two reviews in the past three months. One was positive about access to appointments. Another one feedback they had waited for a phone call that they did not receive.
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Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	7
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>In August 2019 we found the complaint management system to be inadequate as there was no complaint register; complaints prior to 2019 were not available; complaints had not been managed in a timely and satisfactory way.</p> <p>In November 2019 we found improvements in the system and were assured the practice had taken appropriate action to implement a management system. At that inspection we found verbal complaints and concerns were not recorded within the complaint management document and an annual review for themes and trends was not in place.</p> <p>At this inspection we reviewed the complaint system and found:</p> <ul style="list-style-type: none"> • The practice had been reviewing themes and trends on an ongoing basis. An end of year review was planned. • Verbal complaints were now formally recorded within the complaint log. • Complaints were discussed at clinical meetings. • The practice had worked with PALS (Patient Advice and Liaison Service) to review the effectiveness of their system. As a result they had amended the complaint policy and process documents. For example, all patients now received a leaflet for a local patient advocacy service within the complaint letter. • There was a plan in place to provide all staff with complaint management training. We reviewed the training package for this. • The practice recorded feedback including negative feedback received from the friends and family test in another document. This meant there was not full oversight of themes and trends within one management system. During inspection the practice rectified this so all negative feedback would be added to the complaint management log. 	

Examples of learning from complaints.

Complaint	Specific action taken
A patient felt their GP did not follow the recommendations made by accident and emergency.	<ul style="list-style-type: none"> • The patient was invited to the practice to speak to the interim practice manager and a GP partner. • The practice worked with the patient to resolve the concerns.
A patient was unhappy with the care and treatment they had been provided with.	<ul style="list-style-type: none"> • The patient met with the interim practice manager and a GP partner. • The GP spoke to the clinician who carried out the home visits and as a result action was taken to ensure the recording of critical clinical observations were completed after home visits. • The home visit policy was updated.

Well-led

Rating: Good

Previously (August 2019) we rated the provider as inadequate for Well-led because there was not effective governance in the practice and no effective system for identifying, capturing and managing issues and risks. At this inspection we found the culture of the practice and governance systems including risk management were satisfactory.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Following our previous inspection (August 2019) and the subsequent warning notices the GP partners had a programme of assistance from the local medical committee (LMC) and Somerset Clinical Commissioning Group (CCG). An action plan was in place to address our previous concerns and the practice could demonstrate they had been working towards compliance. The LMC were providing practice manager support as the previous practice manager had left employment.</p> <p>At our inspection in November 2019 we found improvements had taken place. The practice was having difficulties employing locum GPs due to a localised lack of GP locums however an additional 30 minutes of appointments had been made available each day. Staff we spoke to told us they had seen more structured and regular staff meetings. They recognised the GP partners had worked towards improving communication and leadership within the practice</p> <p>During this inspection:</p> <ul style="list-style-type: none">• We spoke to staff and the LMC about the leadership at the practice. Staff were positive about the improvements including the GP partners who were open, accessible and supportive. The LMC were positive about the commitment from the leaders to address our previous concerns and ensure actions were completed quickly without compromising safety.• We received feedback from the CCG who recognised the commitment and focus of the leadership team to prioritise and take action.• We reviewed systems and processes and found the GP partners had taken action in response of our previous two inspections.• Since our inspection in August 2019 there had been changes to the partnership with one GP retiring. Another GP was due to retire, and a GP partner had taken on a salaried GP role. We saw succession plans were in place and the GP partners understood the challenges relating to the quality of the service. They were actively addressing them. For example, they had employed an emergency care practitioner.	

Vision and strategy

The practice had a vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
The practice staff were clear about their vision going forward with actions being taken to address our previous concerns including leadership and a unified response from the GP partners. At the time of inspection the vision and strategy were in the process of being imbedded. The focus since August 2019 had been to stabilize the service with a plan moving forward to have a realistic strategy and supporting business plan to achieve its objectives.	

Culture

The practice had a culture which drove high quality sustainable.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Previously the CQC had received a number of concerns from whistle-blowers which we reviewed during our previous inspection and monitoring processes. In August 2019, staff told us they felt the culture did not encourage openness and they felt unable to speak up, unsupported regarding leadership, that there was disharmony within the leadership team and recurrent patterns of no overarching management in terms of an absence of a practice nurse team.	

In November 2019 we saw positive changes with staff telling us of a dynamic shift in practice culture with GP Partners more accessible and supportive. They told us the new interim practice management team had improved staff support, staffing levels and sought to resolve concerns.

During this inspection we spoke to a wide range of staff who were supportive of the changes that were being imbedded to improve the culture. Staff attitudes towards the working environment were extremely positive as they felt listened to and able to speak up. They felt proud to work in the organisation and reflected on the improvements made since our initial inspection on their wellbeing and quality of care patients received. They told us that weekly meetings and daily huddles had improved openness and communication within the practice.

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

Source	Feedback
Administrative, dispensary and reception staff focus group	<ul style="list-style-type: none"> • Staff told us since our previous inspection (November 2019) the practice continued to work hard as a team to implement changes and improvements. They understood the challenges, risks and actions to address these and were supportive and motivated in helping the practice continue on a positive journey. • Recruitment of new staff had improved staffing levels and workload. • Communication from the GP partners continued to be better which helped them to carry out their roles. They felt more included and able to be part of decision making. • Everyone was more relaxed and happier which had a positive outcome on patients.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Previously (August 2019) we told the practice the overall governance was ineffective. In November 2019 we visited the practice and found the practice had an action plan to address concerns. They were implementing and imbedding assurance systems (which would be regularly reviewed and where necessary improved). At this inspection we found the practice had worked hard to deliver improved processes and systems of accountability. However, there were some areas which required further work.</p> <p>We reviewed these areas and found:</p> <ul style="list-style-type: none"> • A formal system for identifying, managing and mitigating risks associated with non-medical prescribers was imbedded. • An overarching system to fully demonstrate compliance with training was in place. • Work had been undertaken to improve the management of the complaint system and processes. 	

- Recruitment processes had been reviewed and changes made in line with NHS Safer Recruitment guidance.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>In August 2019, we found</p> <ul style="list-style-type: none"> The practice had moved from one quality assurance system to another and there was no comprehensive information that the previous system was reviewed regularly or that it was effective. There was no action plan in place to ensure patients were reviewed in line with the new quality system. There were gaps in reviews for long-term conditions due to the resignation of the nursing team. There was limited oversight to ensure processes worked effectively. For example, the management of referrals for secondary care. <p>Since this inspection, the practice had implemented action plans, systems and processes to manage risks, issues and performance. They had taken action to comply with previous warning notices and requirement notices. At this inspection, we found the practice had processes in place to mitigate risks:</p> <ul style="list-style-type: none"> Daily staff huddles, practice meetings and clinical meetings were in place with effective systems to review and manage risks. An ongoing action plan had resulted in improvements to the management of the quality assurance systems and in particular patients with long-term conditions and those living with mental health. A new clinical nursing team were in place with good leadership and systems of assurance. Clinical audits were being undertaken including two-cycle audits however an overarching audit plan had not yet been implemented. 	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y

Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group (PPG).	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
We received positive feedback from the PPG who told us the practice had engaged in PPG meetings. Moving forward the PPG had received agreement from the practice in terms of a PPG plan of action for 2020 and they were positive about future relationships and collaborative working.	
Feedback we received from the local medical council (LMC) and clinical commissioning group (CCG) were positive in terms of the GP partners engagement and management of our concerns. The CCG had undertaken work with the GP partners around leadership and succession planning.	
The leadership team took an inclusive approach, actively involving staff in the delivery of high quality care.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Since our inspection in August 2019 and the subsequent warning notices and inadequate overall rating that practice had demonstrated they had continually improved and worked towards implementing systems and processes to improve the quality of the service.	
During this timeframe their focus had been on improving the current system. However, they had continued to work within their Primary Care Network (PCN) to create a resilient and sustainable general practice for the local population. The practice had a future plan to continue to improve the care and treatment provided to patients. For example, the nursing team were in the process of implementing health promotion evenings.	

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 no statistical variation, 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 no statistical variation 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 Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > 1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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 uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease
- PHE:** Public Health England
- QOF:** Quality and Outcomes Framework
- 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.