

# Care Quality Commission

## Inspection Evidence Table

### Ryalls Park Medical Centre - Yeovil (1-553822687)

Inspection date: 3 March 2020

Date of data download: 24 February 2020

## Overall rating: Requires improvement

We rated the practice as requires improvement overall because:

- Systems to keep people safe and safeguarded from abuse were not fully embedded.
- Systems for the appropriate and safe use of medicines were not fully embedded.
- The practice did not always have appropriate policies to give guidance to staff.
- The practice did not have a formal process to review unplanned admissions or readmissions.
- Publicly available data demonstrated low achievement for patient outcomes.
- The practice was unable to demonstrate actions taken to address concerns raised through national patient surveys.
- Processes to support good governance were not fully embedded.

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

## Safe

## Rating: Requires improvement

We rated the practice as requires improvement for providing safe services because:

- At our previous inspection we rated safe as inadequate. At this inspection we found that the practice had made improvements however, there were still areas where further improvements were required. For example,
- The practice did not have a system to identify vulnerable adults on their system.
- Systems to conduct disclosure and barring service checks in line with practice policy, were not embedded.
- Systems to act on concerns identified in the infection prevention and control audit, were not embedded.
- The practice did not always hold appropriate emergency medicines.
- Staff did not always have appropriate authorization before administering medicines.

### Safety systems and processes

**The practice had systems, practices and processes to keep people safe and safeguarded from abuse but they were not fully embedded.**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 we found that not all staff had received safeguarding training appropriate to their role and in line with national guidance.</p> <p>At our inspection in March 2020 we found that;</p> <ul style="list-style-type: none"> <li>• All staff had completed safeguarding training.</li> <li>• The practice did not have a specific safeguarding adults policy. Following our inspection the practice sent us evidence that a link to the local authority multi-agency safeguarding adults policy was available for staff to access.</li> <li>• The practice did not have a system in place to identify vulnerable adults on their clinical system. Staff told us that vulnerable adults were discussed during the daily huddle meeting, however the practice did not have a formal register in order to identify these patients.</li> <li>• Systems to conduct disclosure and barring service checks in line with practice policy, were in place but not embedded. The practice told us that they did not DBS check non-clinical members of staff but conducted risk assessments in line with regulations. This was not in line with practice policy which stated that all staff who had contact with children or vulnerable adults required a DBS check.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

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: 24 September 2019	Yes
There was a record of equipment calibration. Date of last calibration: 24 September 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 13 February 2020	Yes
There was a log of fire drills. Date of last drill: 27 November 2019	Yes
There was a record of fire alarm checks. Date of last check: 27 February 2020	Yes
There was a record of fire training for staff. Date of last training: Various	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 12 July 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: At our inspection in November 2019 we found: <ul style="list-style-type: none"> <li>The practice was unable to demonstrate that all staff had received fire safety training.</li> <li>Fire alarm checks were not consistently conducted.</li> </ul> At our inspection in March 2020 we found: <ul style="list-style-type: none"> <li>Records demonstrated that all staff were up to date with fire safety training.</li> <li>Fire alarm checks were consistently conducted on a weekly basis.</li> </ul>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 27 February 2020	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	No
Explanation of any answers and additional evidence: At our inspection in November 2019 we found that the practice was unable to evidence that an overall health and safety risk assessment had been conducted.	

At our inspection in March 2020 the practice continued to be unable to evidence that an overall health and safety risk assessment had been conducted. However, we saw evidence that they had completed a premises risk assessment.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 30 January 2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
At our inspection in November 2019 the practice was unable to evidence that all staff had completed infection prevention and control (IPC) training.	
At our inspection in March 2020 we found that all staff were up to date with IPC training. We saw that the practice had conducted regular IPC audits and improvements made were recorded. For example, it was identified that cleaning equipment was not stored appropriately and it had not been recorded when the equipment had been cleaned. This was raised with the cleaning company and improvements were monitored by the practice. However, the practice did not have effective systems to ensure all areas identified as requiring action on their IPC audit, were completed. For example, the practice's IPC audit identified that non-disposable curtains in consulting rooms needed to be cleaned. We discussed this with the IPC lead who told us that they had raised this with practice management who said that this would be looked at as part of the practice refurbishment. There was no record of non-disposable curtains previously being cleaned and no date had been confirmed for the refurbishment.	

## 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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes

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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 the practice told us that they were recruiting additional clinical staff. Patient feedback included that access to GP appointments were a concern.</p> <p>At our inspection in March 2020 recruitment to vacancies remained an issue but there were systems in place to assess and manage staffing levels on a regular basis. The practice told us they were still in the process of trying to recruit additional clinical staff to fill vacancies for one GP and one nurse. The practice had managed to secure a long-term nurse locum during this period. The practice had used locum GPs to provide necessary cover for annual leave and sickness. Information provided by the practice showed that locum GPs had been used to provide cover for 50 sessions over the six months prior to inspection. Feedback from staff included that staffing resources were limited and that it became difficult when one team member was off work. We were told that clinical cover on a standard day included one GP and two nurse practitioners.</p>	

## 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019:</p> <ul style="list-style-type: none"> <li>Feedback from secondary care services included that they were not always given appropriate information when patients were referred to them.</li> </ul> <p>At our inspection in March 2020 we found:</p>	

- Information we reviewed on inspection indicated that referrals contained the necessary information.
- Feedback received from secondary care included that all patients requiring spirometry tests (a test to measure lung function) from the practice were being referred to them. They advised that this was impacting on their resources. We raised this with the practice on inspection who advised that they were actively recruiting for a respiratory nurse but that there was a recruitment shortage in the local area. In the interim period they had managed to secure a locum respiratory nurse who was due to start regular weekly clinics from 2 June 2020.

## Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines, including medicines optimization, but these were not fully embedded.**

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)	5.0%	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)	5.55	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)	2.88	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.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 we found:</p> <ul style="list-style-type: none"> <li>• The practice did not have a formal process to ensure the competency of non-medical prescribers.</li> <li>• The practice did not have a practice specific protocol for monitoring patients prescribed high risk medicines.</li> <li>• Repeat prescriptions requested by secondary care were not always reviewed by a GP before they were issued.</li> </ul> <p>At our inspection in March 2020 we found:</p> <ul style="list-style-type: none"> <li>• The practice had improved their monitoring of non-medical prescribers. We saw that the practice used the Royal College of General Practitioners (RCGP) audit process which looked at five random consultations for each advanced nurse practitioner (ANP). This was conducted on a monthly basis. An ANP evidenced that as part of their clinical supervision, they took their own</li> </ul>	



Medicines management	Y/N/Partial
<p>notes including learning points which were uploaded to their personal development plan (PDP) on the practice's online portal. However, not all relevant staff took notes for their PDP.</p> <ul style="list-style-type: none"> <li>• The practice had introduced a protocol for monitoring patients prescribed high risk medicines and we saw evidence that they were compliant with this.</li> <li>• We saw evidence that additional training had been obtained for staff who dealt with document workflow in the practice. Additional protocols had been introduced which included that all repeat prescription requests were to be reviewed by a clinician. Information we reviewed and discussions held with staff, indicated that they were compliant with this.</li> <li>• The practice did not always hold appropriate emergency medicines. For example, we identified that the practice did not have medicines to treat patients experiencing severe pain or a muscle relaxant for a patient who was fitting. The impact of this had not been risk assessed.</li> <li>• There was not effective oversight to monitor emergency medicines and equipment. We saw evidence that medicines and emergency equipment were regularly checked. However, stock levels identified on the monitoring check list was not fully comprehensive. For example, we found a medicine used to treat suspected bacterial meningitis was held with the emergency medicines, this was not included on the emergency medicines check list. We raised this with the practice on inspection and they advised they would look to update their medicines check list.</li> <li>• Systems to monitor fridge temperatures were not fully embedded. The practice recorded fridge temperatures twice daily however we saw that this was not always consistent. For example, for the fridge in the nurse's cupboard, we identified that temperatures were not recorded in the afternoon on 16 January 2020. Furthermore, for the fridge in the reception area, temperatures had not been recorded for the afternoon on 12 February 2020. The practice's cold chain policy did not give guidance to staff on how fridge temperatures should be monitored and appropriately documented.</li> </ul> <p>The practice told us that they did not have a centralised system for the management and monitoring of Patient Group Directions (PGDs). They told us that they were in the process of drafting a new policy which was due to be reviewed at their next governance board meeting. Our inspection identified that staff did not always have the appropriate authorisations before medicines were administered. We reviewed PGDs and identified:</p> <ul style="list-style-type: none"> <li>• Four PGDs which had been signed by staff after they had been authorized. On three of these staff had signed the PGDs on lines which had been crossed through.</li> <li>• One PGD had been signed by a member of staff but had not been authorised.</li> </ul>	

## 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes



Number of events recorded since 18 September 2019:	14
Number of events that required action:	14
Explanation of any answers and additional evidence: The practice did not have a significant event policy. The practice had a 'being open' policy which gave guidance on how an incident involving a patient should be handled. However, it did not give guidance to staff on how to identify a significant event and it did not give specific detail on the practice's system for handling these events. Staff we spoke with were able to demonstrate an understanding of what would constitute a significant event and we saw that incidents were recorded and acted on.	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
A patient identified that they had not heard anything regarding their 2 week-wait referral. The practice investigated and identified that it had not been fully processed.	The patient was apologised to and the necessary referral was made. The event was raised as a significant event, investigated and discussed at a clinical meeting. It was identified that the referral had not been processed due to human error and the member of staff getting distracted before finalising the task. The practice planned to implement a shortcut on their system to prevent the same incident recurring.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: Our inspection in July 2019 identified that the practice did not have a process to review previous safety alerts to ensure appropriate actions had been taken. At our inspection in March 2020 we found that the practice had implemented a system to monitor safety alerts on their online portal. The portal was used to record the alerts and relevant staff were sent a notification and it was documented when they had read the necessary information. Any actions which resulted from the alerts were also documented on this system.	

**Effective**

**Rating: Requires improvement**

We rated the practice as requires improvement for providing effective services because:

- Uptake for cervical screening was below the national target of 80%.
- The practice could not demonstrate how they ensured effective care coordinate for adults who were vulnerable as had not been identified on the practice's clinical system.

However we saw areas of improvements and positive care, including:

- The practice was able to demonstrate improvements in achievement for patient outcomes.
- All staff were up to date with their training.

### 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 feedback from secondary care services identified that there was not always an appropriate assessment of patients' needs.</p> <p>At our inspection in November 2019 we found that appropriate codes were not always added to patient records. For example, patients who attended the practice for a diabetic review were coded as having received a diabetic foot check. We also identified that mental health reviews conducted in secondary care had not been reviewed by a practice GP.</p> <p>At our inspection in March 2020 we found improvements had been made and that clinical codes had been applied appropriately to patient records and information relating to patients' care and treatment was reviewed by a practice GP where necessary.</p>	

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)	0.48	0.64	0.74	No statistical variation

## 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.
- The practice employed a GP who worked remotely and conducted deskbased reviews for patients with long-term conditions. If they identified concerns, this would be raised with the practice and the patient would be called in for a face-to-face review. We saw evidence that this process was followed.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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)	56.5%	70.1%	79.3%	Significant Variation (negative)
Exception rate (number of exceptions).	3.2% (11)	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) <small>(QOF)</small>	54.1%	68.5%	78.1%	Significant Variation (negative)
Exception rate (number of exceptions).	3.2% (11)	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) <small>(QOF)</small>	66.4%	76.4%	81.3%	Variation (negative)
Exception rate (number of exceptions).	6.5% (22)	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) <small>(QOF)</small>	13.5%	63.5%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	2.0% (7)	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) <small>(QOF)</small>	37.8%	74.1%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	5.8% (6)	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) <small>(QOF)</small>	70.1%	78.2%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	4.0% (31)	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	84.2%	88.3%	91.1%	No statistical variation

currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	1.0% (1)	5.0%	5.9%	N/A

### Any additional evidence or comments

Prior to April 2019 the practice had opted out of fully using the national Quality and Outcomes Framework (QOF), (QOF is a system intended to improve the quality of general practice and reward good practice). The practice used an alternative local quality improvement, the Somerset Practice Quality Scheme (SPQS). SPQS monitored quality and outcomes differently with an emphasis on quality improvement activities. Under the SPQS framework reporting on some indicators such as the QOF data was not used. This meant data for 2018/19, which showed a negative variation in achievement was not representative of the quality work undertaken at the time. Consequently, this practice showed more negative variation for patients with long-term conditions and those with mental health needs when compared with other practices for 2018/19.

Since April 2019 the practice had begun using the national QOF indicators again to monitor patient outcomes. To support effective monitoring of patients' conditions, the practice's business support manager conducted regular audits on the QOF indicators and identified patients who had not attended for a review. This list would be shared with the relevant clinicians who would review their record and try to engage the patient to encourage them to attend for a review.

We reviewed current and projected unverified data for the 2019/2020 QOF year which demonstrated the practice had made improvements in their monitoring of patients with long term conditions. For example:

- Unverified data projected practice achievement for patients diagnosed with asthma who received a review in the preceding 12 months was 92% (target 70%).

Following inspection the practice sent us unverified data to demonstrate further improvements made. For example:

- The percentage of diabetic patients with frailty and a HbA1C of 75 or less was 95% (target 92%).
- The percentage of asthmatic patients in the 2019/20 QOF year, who had had reversibility testing was 98% (target 80%).
- The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness was 95% (target 90%).

## Families, children and young people

## Population group rating: Good

### Findings

- The practice had met the minimum 90% for all four childhood immunisation uptake indicators.
- 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)	69	75	92.0%	Met 90% minimum
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)	52	57	91.2%	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)	52	57	91.2%	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)	52	57	91.2%	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: Requires improvement**

### Findings

We have rated this population group as requires improvement as cervical screening data was below the national target. However we saw areas of positive care.

- 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.
- Unverified data provided by the practice demonstrated improvements for cervical screening uptake, however this was still below the national target.

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	68.8%	N/A	80% Target	Below 70% uptake



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). (Snapshot date: 01/07/2019 to 30/09/2019) (PHE)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	76.6%	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)	59.6%	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)	0.0%	45.6%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	47.9%	56.6%	53.8%	No statistical variation

#### Any additional evidence or comments

The practice was aware that their uptake for cervical screening was below the national target. They told us that they had begun to contact patients by telephone who failed to attend the practice for screening. They said that this process enabled them to further encourage attendance. For example, for patients who failed to attend for screening as they were unsure about the procedure, the practice was able to give reassurance.

Following inspection, the practice sent us unverified data for the 2019/2020 which demonstrated improvements in the number of patients attending for cervical screening, however this was still below the national uptake target of 80%. For example:

- The percentage of patients aged 25-49 who were screened adequately was 74%.
- The percentage of patients aged 50-64 who were screened adequately was 77%.

The practice sent us unverified data for 2019/2020 which demonstrated improvements in the number of patients diagnosed with cancer who had received a review within six months of their diagnoses:

- 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 100%.

#### People whose circumstances make them vulnerable

#### Population group rating: Requires improvement

#### Findings

- The practice were not coding vulnerable adults on their clinical system. This meant that staff maybe unaware of any vulnerability when consulting with these patients, which would have better enabled them to provide appropriate care and support. We were told that the practice had a list of patients who were discussed during their daily 'huddle' meeting.
- 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

We rated this population group as requires improvement because national verified data did

- 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.
- 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.
- 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) <small>(QOF)</small>	3.1%	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) <small>(QOF)</small>	40.6%	55.4%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	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) <small>(QOF)</small>	40.5%	61.6%	83.6%	Significant Variation (negative)

Exception rate (number of exceptions).	2.3% (1)	6.4%	6.7%	N/A
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### Any additional evidence or comments

The above data relates to the period when the practice was still monitoring patient outcomes using SPQS. This meant data for 2018/19, which showed a negative variation in achievement shown was not representative of the quality work undertaken at the time.

Since April 2019 the practice had begun using the national QOF indicators again to monitor patient outcomes.

We reviewed current and projected unverified data for the 2019/2020 QOF year which demonstrated the practice had made improvements in their monitoring of patients with mental health conditions. For example:

- 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 95% (target 90%).
- 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 83% (target 70%).

Following inspection, the practice sent us additional unverified data which demonstrated further improvements;

- Percentage of patients with mental health conditions with recorded blood pressure and a recorded body mass index was 100% (target 90%).

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	298.0	441.3	539.2
Overall QOF score (as a percentage of maximum)	53.3%	78.9%	96.7%
Overall QOF exception reporting (all domains)	3.2%	4.2%	5.9%

Explanation of any answers and additional evidence:

When we inspected on 3 March 2020 unverified data suggested that the practice had achieved 434.33 QOF points out of a potential 485 points. At this time, the practice had not started to apply exception codes to patients records. We were told that a meeting had been planned to discuss patients whose exception coding would be a consideration. The practice told us that across all indicators, this applied to 264 patients. They advised that each patient record would be reviewed and a decision would be made if they should be exception reported.

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

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 we found that audits contained limited information. For example, two audits we reviewed did not show improvements and no action plan had been identified to address this.</p> <p>At our inspection in March 2020 audits we reviewed identified improvements in how these were documented and monitored in the practice. At the time of inspection, audits were focused on prescribing practices and were conducted by the business support manager. Some staff we spoke with who were not currently included in this process, expressed an interest in becoming involved in clinical audit but were not sure if there were plans for this to happen.</p> <p>The practice did not have a formal process to review unplanned admissions and readmissions. The practice told us that the workflow team would send discharge summaries to the patients' usual GP. However no process had been set up to ensure a consistent approach by the appropriate clinician.</p>	

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

An audit was conducted which looked at patients with a repeat prescription for an inhaler but did not have a diagnosis of asthma or chronic obstructive pulmonary disease (COPD). The first cycle conducted in October 2019 identified 37 patients. The second cycle conducted in February 2020 identified 24 patients. The practice told us that they had secured a long term respiratory nurse locum who would be able to assist in reviewing these patients to reduce the numbers even further.

## Effective staffing

**The practice was able to demonstrate that 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.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
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.	Yes

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 the practice was unable to demonstrate that all staff had completed necessary training.</p> <p>At our inspection in March 2020 we saw evidence that all staff were up to date with their training.</p> <p>The practice had made improvements in their monitoring of staff employed in advance clinical practice. They had implemented monthly clinical supervisions with a GP which were monitored by the operations manager. However, we were told that not all non-medical prescribers kept a record of actions and learning identified for their professional development plan.</p>	

## 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)	Yes
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.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

## 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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes

The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
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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)	80.8%	89.8%	95.0%	Significant Variation (negative)
Exception rate (number of exceptions).	1.5% (20)	1.1%	0.8%	N/A

Any additional evidence or comments
The above data relates to the period when the practice was still monitoring patient outcomes using SPQS. This meant data for 2018/19, which showed a negative variation in achievement shown was not representative of the quality work undertaken at the time.
We reviewed current and projected unverified data for the 2019/2020 QOF year which demonstrated the practice had made improvements in their monitoring of patients with long term conditions. Direct comparison data was not obtained for the above indicator, however the practice demonstrated improvements for patients with long term conditions as demonstrated in previous sections.

### Consent to care and treatment

**The practice 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes

**Caring**

**Rating: Requires improvement**



We rated this practice as requires improvement for providing caring services because the practice had not identified specific actions to improve the patient experience following the national patient survey.

### 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.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: On inspection we observed staff treating patients with dignity and respect. We saw staff supported patients with queries relating to accessing appointments, blood tests and access to clinics. Patients were treated in dignified, compassionate and respectful manner.	

CQC comments cards	
Total comments cards received.	21
Number of CQC comments received which were positive about the service.	16
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC comment cards	<p>Positive comments included that patients had seen improvements in the practice, including the attitude of reception staff, over the last year and that staff were helpful and friendly.</p> <p>One patient commented that since May 2019 they had noticed a change in reception staff attitude. That the reception team were more helpful and that they don't feel cautious about attending the practice anymore.</p> <p>Negative comments included that it was difficult to get an appointment.</p>
Interviews with patients	On inspection we spoke with three patients. Feedback included that they were all involved with their care and treatment and that their privacy and dignity was respected.

### 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)	79.2%	91.7%	88.9%	Tending towards variation (negative)
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)	77.4%	90.6%	87.4%	Tending towards variation (negative)
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)	89.1%	96.9%	95.5%	Tending towards variation (negative)
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)	52.2%	85.4%	82.9%	Significant Variation (negative)

Explanation of any answers and additional evidence:

The above information relates to the National GP patient survey conducted in 2019. This was discussed when we inspected the practice in July 2019.

The practice had responded to previous concerns raised regarding reception staff attitude and telephone wait times. When we inspected on 3 March 2020 feedback received from patients on the CQC comment cards demonstrated that patients had recognised improvements made by the practice. For example, feedback included that patients had noticed significant improvements in the last year including reception staff attitude and reduced call wait times. They also noted the positive impact of new clinicians which had joined the team.

Up to date survey results were not currently available when we inspected on 3 March as the 2020 GP patient survey had not yet been completed. However the practice was in the process of conducting their own survey and questions had been targeted to gain feedback on areas of concern, including patients' overall experience of the GP practice.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes
Explanation of any answers and additional evidence:	
The practice had installed electronic feedback facilities where patients could give basic feedback on their experience but were unable to give detailed responses. The practice told us that they were in the process of conducting patient surveys to get feedback on areas of low patient satisfaction. Questions included on the survey focused on areas previously raised as a concern. For example, a question had been included to get feedback on reception staff. There was also the opportunity for patients to give explanations for their answers in order to give specific feedback as well as suggestions for improvements.	

## 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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

## 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)	89.1%	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.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	171 representing approximately 2.8% of the patient population.
How the practice supported carers (including young carers).	The practice had a carers champion who would signpost patients to support organisations.
How the practice supported recently bereaved patients.	The practice told us that where possible, they would conduct a bereavement visit.

## Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
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Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice recognised that the reception area was open which was a potential issue when it came to confidentiality. However to try and manage this effectively, the practice had a sign in reception which marked an advisable distance to wait from the reception desk. This gave patients space to discuss their concerns with receptionists. The practice also advised that they were in the process of negotiating a refurbishment with their landlords and that the reception area would be part of this.</p> <p>The practice told us that they did not have a dedicated room which could be used should a patient wish to discuss something privately, however we were told that a consulting or treatment room would be used in this instance.</p>	

## Responsive

## Rating: Requires improvement

We rated the practice as requires improvement for providing responsive services because:

- The practice was unable to demonstrate actions taken to address concerns raised through national patient surveys.
- Appropriate information on how to complain was not always available to patients.

### Responding to and meeting people's needs

#### Services did not always meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	No
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2019 we found that the practice struggled to provide adequate clinical cover to meet patients' needs.</p> <p>At our inspection in March 2020 the practice told us that they had not reviewed patient demand to identify where additional resources were required. Pre-bookable appointments were made available a</p>	

week in advance. The practice told us that if a clinician wanted to see a patient again, reception would call the patient 10 days before the appointment was required to get this organised. Feedback from patients included that access to appointments was a concern.

We found that continuity of care and appointment flexibility for patients was not always possible due to staffing levels. We found that the practice had managed to employ an additional GP in November 2019. However, vacancies for additional clinical staff had not yet been filled. Feedback from staff included that clinical cover on a standard day consisted of one GP and two nurse practitioners. Locum clinicians were employed to provide additional cover when necessary.

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Appointments available:	
Monday	8.30am to 5.30pm
Tuesday	8.30am to 5.30pm
Wednesday	8.30am to 5.30pm
Thursday	8.30am to 5.30pm
Friday	8.30am to 5.30pm
The practices website stated that additional telephone appointments with the Pharmacist were available weekdays 6.30pm to 8.00pm	

## 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)	92.6%	95.6%	94.5%	No statistical variation

## Older people

## Population group rating: Requires Improvement

Findings
<p>We rated this population group as requires improvement due to concerns identified in the most recent national patient survey and information relating to complaints. This affected all population groups. However, we saw evidence of positive care:</p> <ul style="list-style-type: none"> <li>All patients had a named GP who supported them in whatever setting they lived.</li> <li>The practice was responsive to the needs of older patients, and offered home visits and urgent appointments where necessary.</li> </ul>

- The practice provided effective care coordination to enable older patients to access appropriate services.

## People with long-term conditions

## Population group rating: Requires improvement

### Findings

We rated this population group as requires improvement due to concerns identified in the most recent national patient survey and information relating to complaints. This affected all population groups. However, we saw evidence of positive care:

- 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 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: Requires improvement

### Findings

We rated this population group as requires improvement due to concerns identified in the most recent national patient survey and information relating to complaints. This affected all population groups. However, we saw evidence of positive care:

- 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.
- 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: Requires improvement

### Findings

We rated this population group as requires improvement due to concerns identified in the most recent national patient survey and information relating to complaints. This affected all population groups. However, we saw evidence of positive care:

- The practice had not done analysis on patient demand so were unable to demonstrate how they had adjusted services to meet the needs of this population group. However, as part of the extended hours initiative, additional telephone appointments were available with the pharmacist on weekdays 6.30pm to 8.00pm.
- Pre-bookable appointments were available to all patients at additional locations within the area as part of the primary care network.



**People whose circumstances make them vulnerable**

**Population group rating: Requires improvement**

**Findings**

We rated this population group as requires improvement due to concerns identified in the most recent national patient survey and information relating to complaints. This affected all population groups. However, we saw evidence of positive care:

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- 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: Requires improvement**

**Findings**

We rated this population group as requires improvement due to concerns identified in the most recent national patient survey and information relating to complaints. This affected all population groups. However, we saw evidence of positive care:

- 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 not always able to access care and treatment in a timely way.**

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: Feedback from staff included that there were times when acute appointments were filled by 9.30am. The practice told us that some appointments were held back and released in the afternoon. On inspection we saw that there were still appointments available on the day.	

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)	15.0%	N/A	68.3%	Significant Variation (negative)
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)	30.2%	70.9%	67.4%	Variation (negative)
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)	39.0%	66.3%	64.7%	Variation (negative)
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)	59.3%	77.5%	73.6%	No statistical variation

#### Any additional evidence or comments

When we inspected in July 2019 it was too early to determine if changes previously implemented by the practice had an effect on the patient experience. For example, they had introduced a telephone call back system in May 2019.

At our inspection in November 2019 we identified that the practice had installed an electronic feedback facility for patients where patients could press a button showing different smiley faces to represent how they felt their experience at the practice had been. Feedback received had been largely positive but did not allow for comment.

At our inspection in March 2020 the practice told us that they were in the process of conducting a patient survey in order to get more detailed feedback from patients of their experience including appointment availability and telephone access. The survey was conducted throughout February and continued into March 2020. Results would be collated and presented to the patient participation group. As the survey was still in progress at the time of our inspection the practice were unable to demonstrate to us what sort of feedback they were obtaining to evidence improvements made or to action any emerging concerns.

Source	Feedback
NHS Choices	<p>Three reviews since July 2019.</p> <p>Positive comments included that staff were professional and kind.</p> <p>Negative comments included that it was difficult to access appointments.</p> <p>The practice had responded to all comments and had asked for those raising concerns to contact the practice manager.</p>

## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care, however processes were not fully embedded.**

Complaints	
Number of complaints received since 5 November 2019.	6
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
Explanation of any answers and additional evidence:	
At our inspection in November 2019 we found:	
<ul style="list-style-type: none"> <li>Not all complaints were managed in line with practice policy.</li> <li>Information was not available to patients about how to take action if they were not satisfied with how the practice managed or responded to their complaint.</li> </ul>	
At our inspection in March 2020 we found:	
<ul style="list-style-type: none"> <li>Complaints we reviewed were managed in line with practice policy. Responses to patients included detail of the Parliamentary and Health Service Ombudsman.</li> </ul>	

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence:	
At our inspection in November 2019 the practice was unable to evidence that complaints were used to drive continuous improvement. The practice also did not keep a record of informal complaints.	
At our inspection in March 2020 we found the practice had started to record informal complaints on their online portal and that learning identified from complaints was disseminated to staff. However, the practice's complaints policy was not fully comprehensive. The practice told us that where a complaint was resolved to the patient's satisfaction in 24 hours, this would be classed as a 'concern' not a complaint. Guidance on the parameters of this were not fully comprehensive in the practice's policy.	
The information available to patients on how to complain was not always appropriate. Information given to patients was a copy of the practice's complaints policy. The policy did not give appropriate or up to date guidance on resources available to patients should they wish to complain, for example NHS England. It also did not give detail of the parliamentary and health service ombudsman but referred to the 'health commissioner'.	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient raised a complaint following a delay in their prescription being updated following recommendation by a consultant. The patient had attended the practice a number of times and had supplied numerous copies of the letter.	The practice investigated the concerns raised by the patient and the prescription was updated. An apology and explanation was given to the patient. Additional learning for staff included that they should all be aware of their scanning protocols which included that if duplicate letters are received, they should be destroyed. It was also identified that if a patient raised a

advising of the change in dosage. The patient also became concerned when she queried what happened to the letters she had supplied and no one was able to give her an answer.	concern or query with a member of staff, that member of staff should take responsibility of that concern until it was resolved.
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## Well-led

## Rating: Requires improvement

The practice had made improvements from our previous inspection, however, we still found areas which required further improvement. We have rated the practice as requires improvement for providing well-led services because:

- The practice did not always have appropriate policies to support governance oversight.
- Processes to act on concerns identified in risk assessments were not always effective.
- Systems to ensure staff had the appropriate authorisations to administer medicines, were not embedded.
- Practice oversight of emergency medicines was not effective or in line with policy.
- Processes to ensure the practice was compliant with their disclosure and barring service (DBS) policy were not fully embedded.
- The practice could not demonstrate effective oversight of patients identified as vulnerable or adults on a safeguarding register.

### 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

### Vision and strategy

**The practice had a clear 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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes

Progress against delivery of the strategy was monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 we found:</p> <ul style="list-style-type: none"> <li>The practice was unable to demonstrate that they monitored progress against their action plan to demonstrate improvements.</li> <li>The practice's action plan did not adequately address all concerns to enable improvement.</li> <li>Quality improvement meetings weren't minuted and the practice was unable to evidence items discussed and learning identified.</li> </ul> <p>At our inspection in March 2020 we found:</p> <ul style="list-style-type: none"> <li>The practice held regular quality improvement meetings which were minuted and actions identified recorded on their online portal. To ensure processes were followed appropriately, the practice had implemented a governance board and a supporting governance policy.</li> </ul>	

## Culture

### The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that they did not require their staff to do equality and diversity training as they felt staff already portrayed those values.</p>	

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

Source	Feedback
Interviews with staff	Feedback received from staff included that they felt supported and that the management team were open and honest.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management, however these were not always comprehensive or fully embedded.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 we found:</p> <ul style="list-style-type: none"> <li>• The practice did not have effective oversight of staff training.</li> <li>• Monthly meetings weren't minuted so the practice was unable to evidence actions and learning identified.</li> <li>• Policies and procedures were not embedded and effectively communicated to staff. For example, not all clinical staff were aware of quality improvement processes or audit cycles.</li> </ul> <p>At our inspection in March 2020 we found:</p> <ul style="list-style-type: none"> <li>• We saw that the practice held regular quality improvement meetings and the minutes were held on their online portal. Minutes were available for all staff to review. The practice told us that if there was necessary information which they needed staff to review, they would send a notification round which would confirm when staff had read the required information.</li> <li>• Processes to support effective oversight of staff training had been introduced. All staff were up to date with their training.</li> <li>• The practice had introduced a governance board which had overall oversight of practice processes to ensure the correct procedure had been followed. For example, they would review patient complaints to ensure they had been responded to in line with practice policy. They were also responsible for reviewing new and amended policies and when approved, they would be circulated to practice staff. To support the governance board, the practice had introduced a governance policy which identified the practice's governance structure and how governance would be managed. For example, it included the different meetings held and what information should be covered in each. All processes included in the governance policy were reviewed by the board to ensure compliance. However, we saw that these processes were not always effective as:</li> <li>• The practice was unable to demonstrate that they held appropriate policies to support governance oversight. For example, the practice did not have a significant event policy or a safeguarding adults policy.</li> <li>• Practice policies were not always fully comprehensive to give effective guidance to staff. For example, the complaints policy did not contain information on how staff could effectively identify an informal complaint. The practice's cold chain policy also did not give guidance on how staff should conduct monitoring of fridge temperatures.</li> </ul>	

## **Managing risks, issues and performance**

**The practice had processes for managing risks, issues and performance but these were not fully embedded.**

	Y/N/Partial
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There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial

Explanation of any answers and additional evidence:

At our inspection in November 2019 we found:

- The practice did not have effective systems to identify risk relating to health and safety.
- Governance structures to support the document workflow team, were not embedded.
- The practice could not demonstrate how they were assured of the competence of non-medical prescribers.
- There was not effective oversight of clinical audit or evidence that it was used to drive improvement.

At our inspection in March 2020 we found:

- Assurance systems were in place but these were not always comprehensive to cover sufficient detail. Many of the improvements made since our previous inspections were in the early stages of implementation and therefore had not been fully reviewed to assess the impact of the changes.
- The practice had improved oversight of the document workflow team. We saw that the practice had introduced framework protocols which gave guidance to staff on how documents and information should be processed. Staff we spoke with, were able to demonstrate an understanding of these protocols. Regular audits were also conducted to ensure compliance.
- Oversight of clinical audits had improved. Audits we reviewed gave appropriate information to demonstrate actions taken and improvements identified. The practice told us that audits were discussed as their weekly quality improvement meetings.
- The practice had introduced regular clinical supervision for non-medical prescribers. Staff we spoke with confirmed this.
- Processes to identify and act on items requiring action in risk assessments were not always effective. For example, the practice had not conducted an overall health and safety risk assessment; and concerns identified on the infection prevention and control (IPC) risk assessment had been raised with the practice but had not been acted on. However, we saw evidence that risk assessments had been conducted for specific concerns. For example, legionnaire's disease and fire.
- There was not effective oversight of patient group directions to ensure staff had the appropriate authorisations before they administered the medicines.
- Practice oversight of emergency medicines was not effective or in line with policy. For example, monthly checks on medicines and equipment did not accurately reflect what was held with the emergency medicines. The practice did not have appropriate systems to ensure recommended emergency medicines were held.
- Internal processes were not always formalised to ensure effective oversight. For example, there was no formal process to identify vulnerable adults on the practice's clinical system or to review unplanned admissions and readmissions.
- Processes to ensure the practice was compliant with their disclosure and barring service (DBS) policy were not fully embedded. The practice told us that they did not conduct DBS checks for

non-clinical members of staff but they conducted a risk assessment. Staff records we reviewed reflected this. However, this process was not in line with practice policy.

## 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.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Our inspection in July 2019 identified practice processes to ensure statutory notifications were submitted in a timely way, were not effective.</p> <p>At our inspection in November 2019 the practice was unable to demonstrate effective oversight of quality and outcomes framework (QOF) data and coding issues.</p> <p>At our inspection in March 2020 we found:</p> <ul style="list-style-type: none"> <li>The practice had effective processes to ensure necessary statutory notifications were submitted. At the time of inspection, their registration details were accurate.</li> <li>The practice demonstrated improvements in their oversight of QOF data. Regular audits were conducted to show who had not attended for a review of their condition. This was then followed up by a clinician. Patient records we reviewed, showed that clinical codes were accurate and appropriate.</li> </ul>	

## 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 but this was not always acted on.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019 the practice was unable to demonstrate that they had sought patient feedback on their concerns relating to access to appointments. They also could not evidence that patient feedback of any kind was discussed as a practice.</p> <p>At our inspection in March 2020 we found:</p>	

- Systems to act on patient feedback were not yet embedded. The practice told us that they had prioritised areas for improvement but had not yet addressed areas of concern highlighted in national patient surveys. However, they told us that they were in the process of conducting a patient survey to gain more up to date feedback and would look to discuss the results with their patient participation group.
- Following our inspections in 2019 the practice had worked with the local medical committee to understand their challenges and improve services.
- The practice was part of the Yeovil Primary Care Network however, staff told us that there had been limited contact with other practice teams.

Feedback from Patient Participation Group (PPG).

### Feedback

Feedback from the PPG included that they worked collaboratively with the practice and always looked for ways they could help improve services to patients. The practice attended their meetings, listened to their suggested and implemented changes where possible.

### Continuous improvement and innovation

**There were systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: The practice demonstrated that they had responded to and prioritised concerns identified at previous inspections. However, many of the improvements were newly implemented and therefore the practice was unable to sufficiently demonstrate impact or that they were fully embedded. The practice also demonstrated plans for the future to look at making further improvements to meet patient needs.	

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> 1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.