Irnham Lodge Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Irnham Lodge Surgery on 20 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for older people, people with long-term conditions, mothers, babies, children and young people, working-age population and those recently retired, people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment checks, infection control and medicines management.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Ensure the policy and procedure for safety of GPs bags is carried out including the checks on the calibration of equipment and the processes for checking in and the checking out of prescriptions pads and medicines.
- Ensure that patient's written consent is obtained before specific treatments and clinical interventions are carried out.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There were enough staff to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. One area to improve was identified during the inspection this was in regard to how GPs bags were managed at the practice. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There should be improvements in how patient's written consent for some aspects of treatment or interventions are recorded. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals for all staff. . Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found improvements in making appointments and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and were well equipped to treat patients and meet their needs. Information

Summary of findings

about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Above 10% of the practice patients were 75-84 years old and 57% of patients were over 85 years old. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had implemented named GPs to lead care and support to patients living in care or nursing homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Information from NHS England showed that just below 59% of the patients had long standing health conditions, which was above the national average of 54%. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Just above 12% of patients were less than 14 years of age. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Childhood immunisation rates for the vaccinations given to children under the age of two ranged from 85.5% to 100% and five year olds from 77% to 100%. These were above or comparable to Clinical Commissioning Group/National averages.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). Of the practice patients 54% were from the working population or full time students. Disability allowance claimants were 54% which was above the national average of 50%. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It signposted vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia). There were 73 patients on the practice register with a mental health condition of whom 53 had a care plan agreed. People experiencing poor mental health had received an annual physical health check. The percentage of patients diagnosed with dementia whose care had been reviewed with a face to face consultation during the previous12 months (89%) was above the national average of 83%.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those living with dementia. It carried out advance care planning for patients living with dementia.

Summary of findings

The practice had signposted patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and was planning to improve staff knowledge in supporting patients living with dementia.

Summary of findings

What people who use the service say

We spoke with four patients during the day. We also spoke with four members of the Patient Participation Group. We received information from the 15 Care Quality Commission comment cards left at the practice.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Patients told us they thought they received the care and treatment they needed and they were very satisfied with the service provided at Irnham Lodge Surgery. Feedback from patients confirmed they were referred to other services or hospital when needed. For example, from the NHS Patient Survey for 2014 to 2015, 87% stated their GP was good at listening to them and 88% of patients felt their experience of the practice was good.

Patients said they felt the practice offered a very good service and staff were understanding, efficient, helpful and caring. They said staff treated them with dignity and respect. One patient expressed their satisfaction about the support they had received from their GP and the practice in regard to the support and care given to their child with complex health needs. Another, a young woman was pleased with the support and advice given for contraception. Others were pleased with the care and support for their long term conditions. When we spoke with the four patients on the day of our inspection they all told us they were satisfied with the care provided by the practice and said their needs were being met.

The information from patients showed they were positive about the emotional support provided by the practice staff. They told us that they found the staff to be supportive and very caring.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the policy and procedure for safety of GPs bags is carried out including the checks on the calibration of equipment and the processes for checking in and checking out of prescriptions pads and medicines.
- Ensure that patient's written consent is obtained before specific treatments and clinical interventions are carried out.

Irnham Lodge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Irnham Lodge Surgery

Irnham Lodge Surgery, Townsend Road Minehead, Somerset TA24 5RG is situated in the town centre of Minehead. The practice had approximately 6,584 registered patients from Minehead and the surrounding areas.

The practice is located in purpose built premises attached to a Complementary Health Centre and Pharmacy. There is a central patient waiting room with a reception desk with consulting and treatment rooms leading off these areas. Administration, management and meeting rooms are located on the ground floor and first floor of the building. Somerset Clinical Group commissions Enhanced Services from the practice. A general medical service contract is held with the Bristol, North Somerset, Somerset, South Gloucestershire NHS Area Team. Irnham Lodge Surgery is part of a federation of GP practices in West Somerset.

The practice supported patients from all of the population groups such as older people, people with long-term conditions, mothers, babies, children and young people, working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Over 30% of patients registered with the practice were working aged from 15 to 44 years, 28.9% were aged from 45 to 64 years old. Just above 10% of the practice patients were 75-84 years old and 57% of patients were over 85 years old. Just above 12% of patients were less than 14 years of age. Information from NHS England showed that just below 59% of the patients had long standing health conditions, which was above the national average of 54%. The percentage of patients who had caring responsibilities was 21.6% which is above the national average of 18.5%. Of the practice patients 54% were from the working population or full time students. Disability allowance claimants were 54% which was above the national average of 50%. Patients living in a nursing or care home were 1.9% of the patients the practice supported, which was above the national average of 0.5%.

The practice consisted of five GP partners (3.78 WTE) and one salaried GP. Of these six GPs there were three male and three female GPs. There was one male trainee GP at the practice. There was a nurse practitioner three practice nurses and one health care assistant all of whom provided health screening and treatment five days a week. There were additional clinics implemented when required to meet patient's needs such as the undertaking of influenza vaccinations. There was a team of administration, reception and secretarial staff. The practice had a full time practice manager who was in charge of the day to day management of the service.

Irnham Lodge Surgery had core hours of opening from 8.30am to 6.30pm every weekday. Saturday morning GP appointments were available by advance booking. The practice telephone line was open from 8.00am Monday to Friday. GPs were available from 9.00am to 12.00 noon and again between 2.00pm and 6.00pm. Home visits were usually conducted at lunch time. The practice operated a 'sit and wait' same day appointment system twice a day.

Detailed findings

The practice referred patients to another provider NHS 111, then Somerset Doctors Urgent Care (from 1 July 2015) for an out of hour's service to deal with any urgent patient needs when the practice was closed.

Why we carried out this inspection

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

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

How we carried out this inspection

The practice provided us with information to review before we carried out an inspection visit. We used this, in addition to information from their public website. We obtained information from other organisations, such as the local Healthwatch, the Somerset Clinical Commissioning Group (CCG), and the local NHS England team. We looked at recent information left by patients on the NHS Choices website and information gathered by the Patient Participation Group.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

During our inspection we spoke with three of the GPs including the GP trainee. We also spoke with two practice nurses. We also spoke with the practice manager and the reception and administration staff on duty. We spoke with four patients in person during the day. We also spoke with four members of the Patient Participation Group. We received information from the 15 Care Quality Commission comment cards left at the practice.

On the day of our inspection we observed how the practice was run, such as the interactions between patients, carers and staff and the overall patient experience.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we were given information about how the practice responded to a concern that a patients needs were not truly identified when they contacted the practice resulting in an emergency admission to hospital. The practice reviewed its screening protocols, shared the information with other staff and learning points identified. Since then they have identified that staff were applying the protocols well and patients immediate needs were met.

We reviewed safety records, incident reports and minutes of meetings where these were discussed and shared with all staff. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of six significant events that had occurred during the period from June 2014 to February 2015 and saw this system was followed appropriately. Significant events were a standing item on practice meeting agendas, clinicians met weekly, other staff monthly. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff provided information about the system used to manage and monitor incidents. We saw evidence of action taken as a result and that the learning had been shared for example there had been an incident where reception staff failed to follow the correct protocol for a request for a home visit from another health care professional. This meant there was a delay in the referral reaching the named GP and consequently a later visit occurred which impacted on the timescale of treatment for the patient concerned. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again. The learning from this event was that staff were reminded they should check information received into the practice more thoroughly and there had been no further incidents of this nature.

Another significant event, where a situation arose in the waiting room regarding a sick child. The practice staff initiated an all practice emergency response. The staff followed through with providing emergency care and eventually handed over the patient to the emergency services. Following the event a review of the incident, the practice procedures, facilities and staffs actions were assessed. What the review identified was staff worked well together, remained calm and the response was well coordinated. The review identified that the equipment and skills at the practice were appropriate, staff identified they wished to improve and develop so that they were more confident they could provide the necessary support if the event should occur again. Staff told us they were extending the range of equipment and instigating further training to use this new equipment.

National patient safety alerts were disseminated by the practice manager to practice staff. This was cascaded to relevant staff via email and information was saved electronically for staff to refer to. We were told alerts were discussed at practice policy meetings and staff were directed to further information to refer to and training to update their knowledge, for example hand hygiene.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received training on safeguarding. When we spoke with staff it was apparent that the training they had received was appropriate for their roles. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. The practice

regularly reviewed and updated its policies and procedures and ensured that all staff were aware of any changes made. We saw and heard from staff that safeguarding was a regular topic of discussion at practice meetings.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern if this person was not available. There was a dedicated member of the administration team that ensured information regarding children on the risk registered was received, escalated and shared effectively.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example nursing and administration staff described how patients were 'flagged' with pop ups when their records were accessed. This meant they were able to respond appropriately such as alert the GP that information had been received. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors, palliative care nurses and district nurses. We were told and provided with the minutes of these monthly meetings where information was shared and a planned approach was discussed.

There was a chaperone policy, which was visible on the waiting rooms noticeboards and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Seven of the administration and reception staff had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. We did observe that the vaccine fridges were left unlocked during the day but within a secure area. However, through discussion it was apparent there was not a robust process of ensuring the fridges were locked when the practice closed and domestic staff were present. This was reviewed during the inspection and new protocols put in place immediately. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. There was a central stock-taking system. The practice pharmacist undertook regular audits of all medicines systems in place. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. There were no controlled medicines kept at the practice.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

There was a GP who was a prescribing lead at the practice and another took the lead for the management of controlled drugs. We saw a positive culture in the practice for reporting and learning from medicines prescribing incidents and errors. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Good

Are services safe?

We looked at the systems for managing GPs bags for home visits. We found there was not a consistent approach/ agreement to what each GP carried, how they were stored and who carried out the checks on the contents. Following the inspection we were provided with an updated policy and procedure which clearly set out the systems in place including the checks on the calibration of equipment and the processes for checking in and checking out prescriptions pads and medicines used in the doctors bags.

Cleanliness and infection control

We observed the premises were clean and tidy. We were told contractors were responsible for cleaning, the cleaning schedules and audit of the standards of cleanliness in the building. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, in relation to personal protective equipment including disposable gloves, aprons and coverings. We saw these were readily available for staff to use in all clinical areas. Staff were aware of the needlestick policy and procedures and these were on display prominently in the utility rooms.

The practice had a lead for infection control who had recently been designated the role. We were told they had not yet undertaken further training to enable them to provide advice on the practice infection control policy and carry out audits, or staff training. All staff received induction training about infection control specific to their role and participated in annual updates. The practice provided copies of annual audits for infection control which had been carried out. We could see where areas of improvement were identified and actions taken to rectify the concerns or reduce the risk were implemented. Minutes of practice meetings showed that aspects of infection control, such as sharing the findings of the infection control audit with other staff.

Notices about hand hygiene techniques were displayed in staff and patient toilets, in the utility rooms and nurses' rooms. Hand washing sinks with liquid soap, hand gel and hand towel dispensers were available in treatment or consulting rooms. Liquid soap and paper towels was available in patient and staff toilets.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). All cleaning solutions/ items used that should be managed in accordance to Control of Substances Hazardous to Health Regulations 2002 were kept secure and appropriate information was made available to staff to ensure safe practices were in place.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We saw that detail of clinical staff's immunity status was kept with their employment records and this information was reviewed and updated.

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

Good

Are services safe?

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building and the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Risk assessments were in place where risks were identified. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were in place. The meeting minutes we reviewed showed risks were discussed at all levels of team meetings. For example, fire safety and staff experiences from significant events. We saw that learning needs were identified and actions put in place to implement them.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example there was a daily triage system to respond to patient's urgent care needs. There was a 'red flag' system of symptoms to support staff to refer patients immediately to a GP, accident and emergency department or 999 services. When speaking with GPs, nursing staff, administration and reception staff it was apparent they often pre-empted any concerns and planned ahead for patients who they perceived to be at risk. Staff were acutely aware of the limitations the location of Minehead had with the nearest accident and emergency department in Taunton, at least an hours driving distance away. So care plans and strategies were in place for those known to be most at risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff they all knew the location of this equipment and records confirmed that it was checked regularly. The practice supported one of the practice GPs who was also a First Responder, the only one in West Somerset. They had been trained to provide immediate assistance before the emergency services such as a paramedic, arrived.

We discussed the use of equipment and the skills to use different airways during resuscitation procedures. Clinical staff had identified they would like to develop their clinical skills in this area and would seek further training.

We found emergency medicines were easily accessible to staff in a secure area of the practice. These medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the water company should there be a problem with water supply. We were told that copies of the contingency plan were held off site by key members of the management team and with a neighbouring GP practice. These documents were reviewed annually or when a change of contacts/information occurred.

The practice had carried out regular fire safety risk assessments that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were informed that this guidance and that from local commissioners was readily accessible on line electronically in all the clinical and consulting rooms. We discussed with the practice manager and a GP how NICE guidance was received into the practice. They told us that one GP reviewed and summarised information and disseminated the main points to staff. Full information was made available electronically. New guidance was discussed at team governance meetings, which they called KERMIT. We saw minutes of one of these clinical meetings which showed the implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and were in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes, heart disease and chronic kidney disease were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when needed.

The GPs told us they lead in areas of the management of the service such as prescribing, clinical governance and safeguarding. All GPs had an involvement with caring for patients with long term conditions and the practice nurses provided the support to ensure a planned approach was in place to meet their needs. Clinical staff led on other areas of care for patients such as mental health, sexual health and family planning. The GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. Staff told us about and we saw evidence of sharing of information at practice meetings for developing best practice. The practice used computer document tools to identify and plan for continuity of care for patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling health checks and immunisations. The information staff collected was then collated by the practice manager to support the practice to carry out monitoring to check that targets were met and determine if more detailed audits were required. GPs told us about how other aspects of the service such as NICE guidance and new protocols had triggered an audit, such as treatment for patients with a heart condition.

The practice told us about this one cyclical and other clinical audits that had been undertaken in the last two years. The audit generated from information from NICE identified that the changes implemented following the initial audit had improved the outcomes for patients. There had been an implementation of a planned approach to patient medicines reviews and screening and the involvement of a nurse specialist. We saw that some conclusions had been identified and a re-audit was planned to be carried out in year's time. What also had been identified was clinicians should use a common template to record and plan reviews of patients to assist with the monitoring processes. This approach could possibly be usefully extended to other appropriate conditions.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This

Good

Are services effective?

(for example, treatment is effective)

practice was not an outlier for any QOF (or other national) clinical targets, It achieved 90% of the total QOF target in 2014, which was similar to the national average of 94.2%. Specific examples to demonstrate this included:

- Diabetes related indicators were similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- The percentage of patients diagnosed with dementia whose care had been reviewed with a face to face consultation during the last 12 months (89%) was above the national average of 83%.

The practice was aware of all the areas where gaps in performance with national or Clinical Commissioning Group figures. We saw that achieving targets was discussed at all levels of staff meetings and we saw actions were put in place setting out how these were being addressed.

The practice's prescribing rates were also similar to national figures for example the use of specific types of antibacterial or antibiotics. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There were 73 patients on a register with a mental health condition of whom 53 had a care plan agreed. There was a register of patients with learning disabilities and patients with dementia. The practice also kept a register of patients identified as being at high risk of admission to hospital. Structured annual reviews were also undertaken for people with long term conditions, such as asthma. The practice informed us that the QOF clinical indicators for long term conditions for the year ending 31 March 2015 achieved 432 of 435 points.

Patients told us they thought they received the care and treatment they needed and they were very satisfied with the service provided at Irnham Lodge Surgery.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which some plans for personal development were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from hospital including discharge summaries, Out-Of-Hours GP services and the 111 service both electronically and by post. Out-Of-Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings fortnightly to discuss patients with complex needs. For example, those with multiple long term conditions and those with end of life care needs. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a

shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

GPs told us they held interests and participated in activities outside of the practice. GPs provided services at Minehead Hospital, one provided care and treatment at the CaSH (Contraception and Sexual Health) clinics. One GP served on the Somerset Clinical Commissioning Group. Another worked in conjunction, providing shared care with Turning Point, a drug and alcohol service. Another contributes to Somerset GP Education Trust aimed at GPs, GP trainers and practice nurses.

We spoke with one nursing home manager and a care home manager about the services and support provided by the practice to the people living in their home. We were told the practice and staff worked well with them. They had found the weekly visits helpful and patients had appreciated the dedicated time given to them. They told us communication was good and staff were quick to respond to queries.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP Out-Of-Hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and Out-Of-Hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For example, staff told us of what steps they would take if they had concerns about a patient's capacity to provide informed consent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and the patient's preferences for treatment and decisions were recorded. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). Where difficult assessments were identified these were discussed with other members of the clinical team or external professionals involved with the patient.

We were provided with information from the practice in regard to a review of the decision making and recording in regard to 'Do not attempt resuscitate orders'. DNRs are Do Not Resuscitate orders. This is a legal order which tells a medical team not to perform CPR on a patient. The practice, a care home manager and a representative of Somerset Social Services safeguarding team in January 2015 looked at the different aspects of identifying and recording all decision making and sharing of information. The outcome of this meeting was a shared approach ensuring the correct information was recorded and advice sought to support the GPs from the Local Medical Committee.

We discussed the practice policy and protocol for documenting consent for specific interventions. We could see from a sampled number of patient's records and from feedback from patients that their verbal consent was always asked for prior to interventions or physical contact carried out by the clinicians. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice did have a procedure for obtained written consent for procedures and all staff were clear about when to obtain written consent. However, through discussion it was identified that the document was not sufficiently specific and did not include the insertion of contraceptive devices

Good

Are services effective?

(for example, treatment is effective)

or microsuction. Following the inspection we were provided with a copy of the updated protocol that was much more precise and clear in regard to which interventions were required to have written consent from the patient.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. We noted a culture among the GPs and nursing staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening for young people. The practice also provided access/referrals to other health promotion schemes outside of the practice such as smoking cessation The practice told us about how they worked with federation colleagues to provide guidance to students at a local college to highlight health relationships, issues of exploitation and obtained feedback to inform the Clinical Commissioning Group on how young people wanted to access sexual health services. The practice had been involved with other GP services from the federation in a men's health promotion evening at the local rugby club where they offered blood pressure checks and provided health promotion advice. They told us the evening was well attended and there were plans to repeat the event in the future.

The practice provided a well person clinic offering a blood pressure check and provided advice on health. Health checks were offered to patients between 16 and 75 years of age to patients who had not been seen at the practice for over a period of three years. The practice also offered annual health checks to all its patients aged over 75 years either at the surgery or at the patient's own home if necessary.

The practice enabled patients to access national screening programmes. Such as cervical screening and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For example, influenza vaccination rates for the over 65s were 71%, and at risk groups 52%. These were similar to national averages. Childhood immunisation rates for the vaccinations given to children under the age of two years old ranged from 85.5% to 100% and five year olds from 77% to 100%. These were above or comparable to Clinical Commissioning Group/ National averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from NHS Choices, friends and family test and any surveys carried out by the Patient Participation Group (PPG). We spoke with four patients in person during the day. We also spoke with four members of the Patient Participation Group. We received information from the 15 Care Quality Commission comment cards left at the practice. Information showed that patients were satisfied with how they were treated and this was reflected in the comments we received. For example from the NHS Patient Survey for 2014 to 2015, 87% stated their GP was good at listening to them and 88% of patients felt their experience of the practice was good.

Patients said they felt the practice offered a very good service and staff were understanding, efficient, helpful and caring. They said staff treated them with dignity and respect. One patient expressed their satisfaction about the support they had received from their GP and the practice in regard to the support and care given to their child with complex health needs. Another, a young woman was pleased with the support and advice given for contraception. Others were pleased with the care and support for their long term conditions. When we spoke with the four patients on the day of our inspection they all told us they were satisfied with the care provided by the practice and their needs were being met.

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

We saw that staff maintained confidentiality when discussing patients' treatments so that information was kept private. Telephone enquiries and calls for appointments were taken away from the reception area which helped keep patient information private.

Care planning and involvement in decisions about care and treatment

Information from patients we spoke with showed patients experienced being involved in planning and making decisions about their care and treatment and generally felt the practice did well in these areas. Patients also felt the GP was good at explaining treatment and results. This was also reflected in the comments received about the practice nurses. If a patient decided to decline treatment or a care plan this was listened to and acted upon.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Information from the Patient Participation Group meetings and discussions with the practice staff team revealed that this service was required very infrequently but when used was effective and useful to help support the patients involved.

Patient/carer support to cope emotionally with care and treatment

The information from patients showed they were positive about the emotional support provided by the practice staff. They told us that they found the staff to be supportive and very caring.

The practice told us they offered longer appointments for patients who needed them to aid communication. They also told us they always tried to check with patients that the gender of GP met their choices and they aimed to provide continuity of care by providing a named GP.

Notices in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice newsletter also provided details of local support groups and services. The practice's computer system alerted GPs and other staff if a patient was also a carer. The practice had a member of staff who was a carers champion, signposting and supporting carers to external support groups and services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and the needs of the practice population were understood and systems were in place to address their identified needs. For example, through the practice patient survey and feedback in 2014 changes were made to the appointment system to provide quicker access to GP appointments. The practice now offered a 'sit and wait' service twice a day where patients attended the practice and waited in turn to see the GPs on duty. Staff and patients told us there had been mixed feelings about this service at the beginning. However, as patients had become more used to the service it had been used well and patients appreciated the ability to be seen on the day they presented their problems.

There was a computerised system for obtaining repeat prescriptions and patients used both the email request service, posted or placed their request either in a drop box in reception or outside the building. Patients told us these systems worked well for them.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice, including the implementation of greater access to appointments, a clock and improvements to the child play area in the waiting room.

Tackling inequity and promoting equality

The practice had recognised they needed to support people of different groups in the planning and delivery of its services. The practice manager with the PPG had looked at the information and demographics, of the population group the practice serves. They identified there were no significant issues they needed to address apart from encouraging young people to be involved and take an interest in what the service provided.

Irnham Lodge Surgery was a purpose built extension to a large residential property near the town centre of Minehead. The practice shared the entrance way with the Complimentary Therapy Service that was based in the original building. The reception and the main patient areas were on the ground floor of the building. Meeting rooms on the first floor of the Complimentary Therapy Service were used by the practice for board and staff meetings. These were accessible via the lift or stairs.

Patient areas were accessible and suitable for wheel chair users and people with limited mobility. Accessible toilet facilities were available and the practice had baby changing facilities.

Access to the service

Irnham Lodge Surgery had core hours of opening from 8.30am to 6.30pm every weekday. Saturday morning GP appointments were available by advance booking. The practice telephone line was open from 8.00am Monday to Friday. GPs were available from 9.00am to 12.00 noon and again between 2.00pm and 6.00pm. Home visits were usually conducted at lunch time. The practice operated a 'sit and wait' same day appointment system twice a day. The practice referred patients to another provider NHS 111 for an out of hour's service to deal with any urgent patient needs when the practice was closed.

Like other practices in the area Irnham Lodge Surgery provided services to the holiday population visiting the area. Patients were able to register as a temporary resident of the area. The practice turnover of patients was just below 8%.

Information was available to patients about the opening times and appointments on the practice website, these were also available on display in the practice waiting areas and provided to patients when they registered with the practice. This information included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave patients the telephone number they should ring for the Out Of Hours service

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment were able to either speak to a GP or attend appointments on the same day of contacting the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There were designated responsible leads, a GP for clinical issues and the practice manager for the administration and management of the service, who handled all complaints in the practice.

Information was available to help patients understand the complaints system. It was included in the practice information leaflet, on display in the patient areas and the practice website. The information contained details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. The patients we spoke with did not alert us to the fact they did not know of the complaints process and were aware of the process to follow if they had a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the information about the six complaints the practice had received in the seven months from October 2014 to May 2015. The complaints ranged from a variety of issues, some were in regard to waiting times to go in for an appointment, missed medicines on a repeat prescription and problems with cancelling and re-booking an appointment for a minor surgical procedure. The complainant had been kept informed about the complaint investigation and the outcome. The practice had looked at how it could improve and avoid incidents recurring and patients raising similar complaints in the future. There was evidence that staff had put changes in place including changes in administration practices. Patients had the opportunity to make comments; a comments box was available in the practice reception. Patients also expressed their opinion about the service on NHS Choices. Each comment was responded to by the practice and learning and actions put in place to prevent recurrence. Equally compliments were reviewed by the practice and patients were responded to and thanked for their feedback.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide a range of NHS GP services to temporary residents of the area and fully registered patients at the surgery, to treat all patients promptly, and with courtesy and care at all times in a safe and clean environment. They also stated confidentiality and information governance was of paramount importance and patients should expect to liaise with the practice team in complete confidence at all times.

When we spoke with the GPs, practice nurses and members of administration staff, they all understood the vision and values of the practice and the aim of the practice team to achieve good outcomes for patients and the community.

Governance arrangements

The practice had a number of policies and procedures in place to govern how services were provided. These policies and procedures were available electronically, some in hard copy for easy access. There was a system to ensure that policies and procedures were reviewed and updated where required on an annual basis. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, medicines management and vaccines.

There was a leadership structure with named members of staff in lead roles. For example, the lead nurse supported the nursing care provided at the practice. A GP partner was the lead for safeguarding and a lead GP for Clinical Governance. One GP was the prescribing lead for medicines another for data management and IT in clinical matters. Practice nurses took responsibility for areas such as infection control. The practice manager and some of the administration team were responsible for health and safety, supporting the PPG and IT. . All of the members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. It achieved 90.4% of the total QOF target in 2014, which was similar to the national average of 94.2%.

The practice had carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, looking at prescribing practices for one specific treatment for a cardiac problem.

The practice had arrangements for identifying, recording and managing risks. Risks were identified and managed effectively and action plans had been produced and implemented. These included those relevant to health and safety and the delivery of the service.

The practice partners and salaried GPs had a system of daily, weekly and monthly meetings for governance, business and to discuss patient's needs. Patients' needs were discussed on a daily basis; there were fortnightly meetings with multidisciplinary teams for patients who required more support. Monthly meetings were held to monitor patients who were assessed and were identified as vulnerable or at risk, such as children who were of concern.

Leadership, openness and transparency

Practice staff met monthly to discuss the service delivery within their own peer groups. Important information was disseminated between these meetings should urgent issues arise. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice employed a practice manager who oversaw the administration and management of the service. Their role included being responsible for human resource policies and procedures and their implementation. We reviewed a number of policies, such as those for aspects of health and safety found they were up to date and had the required information.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. We looked at the results of the annual patient surveys and saw that patients had highlighted a range of issues that they thought could be improved. This included providing better access to appointments and telephone contact/ triage with a GP which reduced the need to attend the practice for an appointment when advice was readily available.

The practice had a virtual patient participation group (PPG) that had supported the practice to carry out annual surveys. We met and spoke with representatives of the PPG who told us about their involvement with the practice and

Are services well-led?

Good

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

the plans they had for developing the relationship and support to the practice patients. They provided information of how the practice had listened and responded to the questions they raised and the feedback they had provided. Examples of this were the improvement in the décor in the waiting room and how suggestions patients put forward in suggestion cards left in the reception areas were responded to and acted upon.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. This enabled staff to raise concerns without fear of reprisal.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff confirmed that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they were provided with opportunities to develop new skills and extend their roles.

We heard how the practice was a teaching practice and much valued the support they were able to provide to GP trainees. Two GPs at the practice were qualified GP trainers. They told us they had found it a two way learning process prompting GPs at the practice to keep up to date and develop new skills and interests.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients.