Langport Surgery

Quality Report

Langport Surgery
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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 Langport Surgery on 17 November 2014. Overall the practice is rated as good.

Specifically we found it good for well-led, effective, caring and responsive 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 were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and knew how to report incidents and near misses. Information about safety measures were recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed. Staff were trained and 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
- 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 told us they were treated with compassion, dignity and respect and that they were involved in their care and decisions about their treatment.
- Information about the services provided and how to complain was available and easy to understand.
- The practice had good facilities and was 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 upon.
- The practice was a GP training practice. There was a practice focus on the development of individuals and involvement in research projects.

We saw several areas of outstanding practice including:

Summary of findings

- The practice worked well with other health care services outside of the local area, and with other public bodies such as the fire service, police and rescue services as the area experienced flooding in 2014.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned from incidents and complaints and communicated to staff and actions were put in place in order to prevent reoccurrence. Information about safety measures were recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. There were safe systems in place for the dispensing of medicines from the pharmacy within the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Information from NHS England and the practice showed that patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and treatment and support was planned and delivered to meet those needs. Care plans were in place for patients who had long term care or complex health needs. For patients deemed to be at a higher risk in respect of their ability to make decisions we found that there were systems in place for assessing capacity and decision making. The practice provided information and support to patients for promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and training planned in order to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was support provided to patients and carers to enable them to cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment and 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. The staff and the practice had a very

Summary of findings

flexible approach to providing support to patients and to the local community surrounding the practice. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood and supported the ethos of the practice. 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 upon. The patient participation group (PPG) was active. The practice was a GP training practice; it also provided practical experience for medical and nursing students. There was a focus on the development of individuals and involvement in research projects. Staff had received inductions, regular performance reviews and had attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Information received from NHS England showed us that 15% of the practice patients were aged between 65 and 74 years. Around 8% of the practice patients were 75-84 years old and just under 4% of patients were over 85 years old. The practice offered proactive, personalised care to meet the needs of the older people in its population. Each patient over the age of 75 was provided with a named GP. There was multidisciplinary team working to support patients to remain in their own homes and prevent hospital admissions. The practice staff were responsive to the needs of older people and provided higher than the average expected number of home visits for patients who required this service.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Information from the Somerset Clinical Commissioning Group (CCG) showed that 53% of the patients had long standing health conditions, which was similar to the national average. Nursing staff had lead roles in chronic disease management. Patients who had been deemed at risk were provided with support from multidisciplinary team. Care plans were in place to prevent hospital admissions. Longer appointments and home visits were available when needed. These patients had an annual review to check that their health and medication needs were being met.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. Immunisation rates were relatively high for all standard childhood immunisations in comparison to the national average. Appointments were available outside of school hours and the premises were suitable for children and babies.

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). Over 28% of patients registered with the practice were working aged from 15 to 44 years, 30.5% were aged from 45 to 64 years old. 1% of the working population were unemployed which is below the national average of 6.3%. The needs of the working age population, those who could not attend the practice during working hours were met by offering

Summary of findings

access through extended hours and on Saturday mornings. The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

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 and annual health checks were offered to provide extra support to them. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people or people seen as at risk. The practice provided patients access to and gave information about 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 knew how to contact relevant agencies. The percentage of patients who had caring responsibilities was just over 20% which is above the national average of 18.5%. The practice had systems in place to monitor and support patients who had caring responsibilities.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with poor mental health were offered an annual physical health check. The practice staff worked regularly with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. All of these patients had a care plan in place. Patients also had access to a counsellor, substance misuse key worker and a psychiatrist specialist in the care of older patients.

Summary of findings

What people who use the service say

We spoke with four patients during the day. We received information from the 16 comment cards left by patients at the practice premises.

Patients said there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Feedback from patients we spoke with confirmed that communication was good between the practice and other staff associated with the practice.

When we spoke with patients they told us that consent was asked routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if they declined this was listened to and respected. Patients confirmed their GP involved them in care decisions and they to us that they also felt the GP and other staff were good at explaining treatment and results. Patients told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Information showed that patients were satisfied with how they were treated. Patients said they felt the practice offered a more than excellent service and also told us that staff were understanding, efficient, helpful and caring. They also said that staff had treated them with dignity and respect. Patients were positive about the emotional support provided by the practice staff such as the empathy shown to them and told us that the staff were supportive and very caring. If they requested urgent attention, patients were always seen on the day of their request, this included patients requiring home visits.

Representatives from the Patient Participation Group said the practice listened to them about the comments patients made about the service. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Langport Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP Specialist Advisor.

Background to Langport Surgery

Langport Surgery is situated in the rural town of Langport, Somerset. The practice had approximately 12,000 registered patients including those patients from the outlying villages of Muchelney, Curry Rivel, Long Sutton, Somerton and Burrow Bridge. The practice provides care and support to patients residing in nursing and care homes in the area. Based on information from NHS England, we found that1.3% of patients registered at the practice lived in residential homes.

The practice is located in purpose built premises on one level. There is a central patient waiting and reception area with consulting and treatment rooms accessible from this area. The practice is on a general medical service contract with Somerset Clinical Commissioning Group. The practice is a dispensing practice which means it provides patients registered with them with the medicines they are prescribed.

Langport Surgery is only provided from one location:

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North Street

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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 28% of patients registered with the practice were working aged from 15 to 44 years, 30.5% were aged from 45 to 64 years old. Of the practice patients15% were aged between 65 and 74 years. Around 8% of the practice patients were 75-84 years old and just under 4% of patients were over 85 years old. 15% patients were less than 14 years of age. Information from the Somerset Clinical Commissioning Group (CCG) showed that 53% of the patients had long standing health conditions, which was similar to the national average. The percentage of patients who had caring responsibilities was just over 20% which is above the national average of 18.5%. 1% of the working population were unemployed which is below the national average of 6.3%.

The practice consisted of five GP partners who employed two salaried GPs. Of these seven GPs there were five male and two female GPs. The practice was a training practice with up to two GP trainees at any one time. There was a nurse practitioner, five practice nurses and a phlebotomist (blood testing) 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. Two health care assistants were employed for domiciliary phlebotomy (blood testing) which means that patients who had difficulty in leaving their home could have the tests they required. The practice telephone was open to patients from 8am to 6:30pm. The practice was open from 8.30am to 7.20pm on Monday and 8.30am to 7.10 on Tuesday and

Detailed findings

Wednesday. On Thursday and Friday each week the practice closed at 6.30pm. The practice had appointment only access for patients on Saturdays from 8.00am to 11.00am. 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.

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.

This provider had not been inspected before and that was why we included them.

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.

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 visit we spoke with five of the GPs, the nurse practitioner and one practice nurse. We also spoke with the locum practice manager and the reception and administration staff on duty. We visited and met with staff employed in the dispensing pharmacy. We spoke with four patients in person during the day. We received information from the 16 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 and staff and the overall patient experience.

Good

Are services safe?

Our findings

Safe track record

We spoke with five GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about 16 incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included a delay in diagnosis, gaps in communication information sharing between agencies. We also saw that events linked to the pharmacy in respect of service errors or occurrences, such as the wrong medicines given to a patient of the same name had also been reviewed

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken to learn from these events. Steps taken included providing information to care providers who were supporting the patients in their home, this was in order to ensure continuity of care.

We saw evidence that national patient safety alerts as well as comments and complaints received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events.

Members of the practice staff had undertaken Leading in Safety and Quality (LISQ) training during 2013/2014 with the NHS Institute for Innovation and Improvement. Following this training the practice had implemented projects that included reviewing the process of patients' medication reviews and a premises safety audit. The outcomes of these projects were patients prescriptions were provided within a risk assessment process whilst waiting to for a review of medication appointment. A premises safety audit had prioritised the risks and a programme of repair, refurbishment or replacement put in place.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and practice manager. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role. Administration and reception staff were supported to complete SEA forms and follow them through when events occurred. A process map was on display in reception to ensure appropriate steps were taken in line with individual roles and responsibilities.

We saw from summaries of the analysis of these events and a review of complaints which had been received that the practice had put actions in place in order to minimise or prevent reoccurrence of events. For example, revisiting information and reviewing the procedures for ensuring patients information is correct and in place for advanced care and support. For example, the practice had ensured discussions and records were accurate for the emergency resuscitation wishes of patients living in local care homes.

Safety alerts and information was available on the electronic records for staff to readily access. The practice told us they were reviewing how they managed and responded to SEA and complaints received. They had identified the need to look at the root causes of events and complaints, to involve a wider group of staff and to improve documentation.

Reliable safety systems and processes including safeguarding

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

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. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues

when patients attended appointments; for example children subject to child protection plans. We were shown examples of this information and found that the information was recorded effectively and appropriately.

GPs were appropriately using the required codes on their electronic case management system. This ensured risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead GP for safeguarding was aware of vulnerable children and adults and of the records identifying these patients. Information from the GPs demonstrated good liaison with partner agencies such as the police and social services. They participated in multi-agency working for patients who were at high risk of admission to hospital or A&E by maintaining a register and creating a care plan appropriate for the individual. Through discussion with staff it was clear that patients at risk were discussed and information shared appropriately with other staff at the practice.

We heard also about the monitoring, follow up and checks made by the practice when patients who had been deemed at risk who did not attend for appointments such as childhood immunisations.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. Patients told us they were aware of the availability of chaperones if they required it.

Medicines management

We looked at the systems for medication used at the practice. We also looked the dispensing pharmacy service the practice provided.

Staff told us about the practices for safe medication administration and storage at the practice. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Controlled medications were managed by staff working in the dispensary. There was a safe system in place for storage, administration and dispensing controlled medicines at the practice.

The practice had a GP who was the medicines management lead. They were able to describe the processes in place for reviewing prescribing at the practice. We heard how information about the medicines prescribing at the practice was reviewed and discussed in team meetings and clinical audits. For example the use of antibiotics in conjunction with the use of other medicines and the effects for patients.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance; these were tracked through the practice and kept securely at all times.

We met and spoke with staff working in the dispensary at the practice. We were told the practice provided medicines to 7,200 patients. Part of their service was to provide medicines in monitored dosage systems; they also had an additional service of home delivery for those housebound patients. They provided a service to the rural communities and delivered these twice a week to eight communities in the surrounding areas using the community bus service and post office delivery service in order to carry this out.

Dispensing staff at the practice described and showed us how they managed patient's prescriptions. Staff were aware that prescriptions should be signed by the GP before being dispensed. We were shown the checks and the systems of monitoring for patients prescriptions and the dispensing at the practice and found these to be satisfactory.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Good

Are services safe?

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. New staff were commenced on training when appointed and were supported by experienced staff.

The practice had established a service for patients to pick up their dispensed prescriptions at the eight locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the practice premises to be clean and tidy. Patients we spoke with and who provided feedback to us in the comment cards said they had found the practice clean, hygienic and had no concerns about infection control. We saw there were cleaning schedules in place and cleaning records were kept.

The practice had a lead person responsible for infection control. This person told us they training scheduled for January 2015 in order to enable them to provide advice on the practice infection control policy and to cascade their learning to other staff at the practice. All staff had received induction training about infection control which was specific to their role and had received annual updates. We saw evidence that the lead person had carried out a recent infection control audit and improvements had been identified for action. Immediate improvements needed had been addressed. An action plan was to be developed for the other areas such as flooring, replacement of furniture or cleaning schedules. The provider had also identified that some of their clinical protocols, for example specimen handling, were in need of updating.

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, personal protective equipment including disposable gloves, aprons and coverings were available for staff use.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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

Equipment

Staff 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. We saw equipment maintenance logs and other records which 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, and blood pressure measuring devices.

We were told about the investments made by the practice for the availability of equipment in order to enhance patient experience and reduce the need to travel to the nearest acute hospital for tests. This equipment had included a 24 hour blood pressure monitoring machine and cardiac events monitor. The practice had purchased new emergency equipment such as an automated external defibrillators (used to attempt to restart a person's heart in an emergency), including a portable defibrillator in order to respond to external events.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Clinical staff were required to provide information about their immunisation status such as Hepatitis B (Hepatitis B virus is a viral infection carried in the blood causing inflammation of the liver and potentially long term damage). The practice offered to provide immunisation for Hepatitis B if the member of staff did not have it.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that new staff were provided with

Good

Are services safe?

information about their job role and the key policies of the practice. Each member of staff was provided with a staff handbook which informed them of their employment responsibilities. Copies of their contractual agreement were also kept.

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. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

We saw that any risks were discussed within team meetings. Welfare, clinical risks and the risks to patient's wellbeing were discussed daily and weekly by the GPs and nursing staff. There were systems for monitoring patients with long term conditions, end of life care and patients being treated for cancer.

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. The GPs had invested in emergency equipment and on-going training to respond to roadside or at home incidents for patients. The practice is located in an isolated location and is not near to emergency services. The practice had responded effectively to two roadside incidents during the last four years.

All members of staff, they all knew the location of this equipment and records confirmed that these were checked regularly. Emergency medicines were stored safely. Medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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 had been 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 power company and telephone service provider. They also had details of the contingency plans for relocation of the practice and services should access to the building be prevented, This policy had been updated in October 2014 and it reflected working with the local Clinical Commissioning Group to ensure continuity of medical services to the area.

The practice had carried out a fire risk assessment 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 told us about their approaches to providing care, treatment and support to their patients. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told how this information was shared at the practice, this could be seen in minutes of practice meetings where the new guidelines were disseminated The implications for the practice's performance and patients were discussed and actions had been agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and saw that these were reviewed when appropriate.

The practice used an assessment tool to help identify high risk patients and participated in joint working with other health and social care professionals to prevent unplanned hospital admissions. Care plans were in place for people who had long term or complex health needs.

The GPs told us they had lead roles in specialist clinical areas such as respiratory disease, diabetes, heart disease and stroke management. The practice nurses supported the GPs with this work for patients with on-going long term conditions. We heard about a GP who had qualifications in sports medicines. All of the GPs were involved in some aspect of clinical research with one GP taking the lead with this area. GPs and nursing staff were open about asking for and providing colleagues with advice and support. The GPs and nursing staff had discussions in regard to improving outcomes for patients. Minutes of meetings and Significant Events Analysis (SEA) confirmed that this happened.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included child and adult protection, a named GP for patients over 75 years of age and medicines management. The information collected was then collated by staff and the lead GPs in supporting the practice to carry out clinical audits. We heard how the practice used information from audits in relation to prescribing specific medicine combinations for treatment for depression or mental health disorders. This had been done in order to identify if there was a greater risk of medicine changes in respect of heart rhythms.

The practice showed us three of clinical audits that had been undertaken in the last year. One was to establish if appropriate dermatological referrals had been made in regard to the final diagnosis. The resulting analysis was that the practice had y made appropriate referrals in a timely way. A second audit was carried out in regard to patients already identified as having a pre-disposition to acquiring diabetes. Patients were put on a recall system if they had not been seen during the last 12 months and blood tests carried out. From this recall 42 patients attended the practice for tests and none were found to have developed symptoms of type 2 diabetes. Patients were supported with their treatment plan.

Another clinical audit looked at the use and prescribing of medicines for patients with known kidney disease. The practice monitored patients with this diagnosis, they were informed of the potential risks and the practice ensured that regular checks were carried out. We saw that this audit found that the recording mechanisms in patients' notes required further development. The practice had a plan of re-audits and the most recent in September 2014 showed that through better recording and monitoring they had reduced the number of patients being prescribed these specific medicines. There was also improved recording of the conversations about the potential risks with the patients.

The practice also used the information collected for the Quality Outcomes Framework (QOF), the local Somerset Quality Practice Scheme and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for Quality Outcomes Framework (QOF). For example patients with diabetes, asthma, and a diagnosis of dementia had, had their care plan reviewed in the previous 15 months. This practice was not an outlier (variation in expected figures) for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

Staff we spoke with were very positive about the culture in the practice in respect of audit and quality improvement. There was an expectation that all clinical staff should undertake or become involved in the audits carried out.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients who received repeat prescriptions had their medicines reviewed annually by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. It 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. The practice had dedicated GPs assigned to the nursing and care services it supported. There was a focus on meeting patient's needs in the community, particularly patients who were housebound and required long term care and support.

The practice also participated in research we were told the current programme was in regard to bowel and lung cancer. One research project had reviewed patients with atrial fibrillation for the last three to four years. We were not provided with detail of the current findings of these research projects.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with one having an additional diploma in sport health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We were informed that all partners had five days study leave per year, and half days were also taken occasionally for staff training. We found the lead GPs had obtained specific training they required such as revisiting safeguarding children training at level three, providing support and mentoring to GP registrars, trainee doctors foundation year two, medical and nursing students.

Staff told us that annual appraisals identified learning needs from this action and plans were developed and documented. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. The practice was a training practice, GPs who were training to be qualified as GPs offered extended appointments to patients and they also had access to a senior GP throughout the day for additional advice and support if needed. We received positive feedback from some of the GPs we spoke with about the support they had from the practice. We heard they had remained or returned to the practice when their training had completed as they had enjoyed working at the practice.

Practice nurses and the nurse practitioner had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they had completed training on the administration of vaccines, cervical cytology and family planning. Health care assistants had been trained appropriately to carry out phlebotomy (blood testing).

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife and the district nursing team. The practice hosted a physiotherapist, podiatrist, ulcer clinic and a nail cutting clinic. Patients also had access to a counsellor, dietician, substance misuse key worker and a psychiatrist who specialised in older people. Feedback from patients confirmed that communication was good between the practice, the attached staff and those who hosted services at the practice.

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. Regular meetings with other professionals such as the community matron, district nursing teams, health visitors, palliative care team and social workers took place. Staff felt this system worked well and there was a team approach to supporting their patients.

Good

Are services effective?

(for example, treatment is effective)

The practice worked well with other health care services outside of the local area, and with other public bodies such as the fire service, police and rescue services as the area experienced flooding in 2014.For example, it worked in conjunction with other GP services, supporting patients to receive treatment and their medicines when they were unable to attend or receive home visits from their own GP. The practice set up weekly surgery sessions in a local church and carried out home visits on behalf of other GP practices.

The practice staff arranged and delivered patients medicines with assistance from volunteers, PPG and the emergency services using unusual methods of transport such as via boat. The practice staff liaised with the community coordinator for the village of Mulchelney to ensure that support was provided to patients identified at risk. An emergency drug collection point was also put in place.

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.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called EMIS to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. 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 in their practice.

Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved with. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lack capacity. One GP gave an example of best interests' assessment and how this was carried out appropriately during a recent event where a new patient had been admitted to a local nursing home. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions including a patient's verbal consent which was recorded in the electronic patient notes.

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

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. New patients' health concerns were identified and arrangements made to add them into long term health monitoring processes such as the diabetes, asthma or heart conditions clinics or health reviews. The practice provided information and support to patients to help maintain or improve their mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to patients who smoke. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

We were told there were very few patients, or temporary patients, registered with the practice that came from at other risk groups such as people who were homeless or travellers in the area. The population group of patients with learning difficulties was low. The practice identified patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability these patients were offered an annual physical health check. There was a programme for cervical smear uptake within this there was a system for following up

Good

Are services effective?

(for example, treatment is effective)

patients who did not attend screening. A similar mechanism of following up patients was in place for patients who did not attend health screening appointments or clinics.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all child immunisations was above average for the Somerset Clinical Commissioning Group and again there was a clear policy for following up patients who did not attend appointments.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice. For example, sexual health services for younger people.

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 a survey of 500 patients undertaken during 2013 to 2014 by the practice's patient participation group (PPG) in partnership with the practice staff. Information showed that patients were satisfied with how they were treated and this was reflected in the comments we received.

There were 16 patients who completed CQC comment cards to tell us what they thought about the practice. 15 of these were positive about the service they experienced. Patients said they felt the practice offered a more than excellent service and staff were understanding, efficient, helpful and caring. They said staff treated them with dignity and respect. One patient expressed their dissatisfaction about the delay in seeing their GP at the agreed appointment time. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 followed the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was set back from the reception desk and was partially shielded by glass partitions 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 and health care assistants.

Patients we spoke with on the day of our inspection told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. If they 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.

Patient/carer support to cope emotionally with care and treatment

The information from patients showed patients were positive about the emotional support provided by the practice staff. For example, one person told us about the empathy shown to them in regard to their problems and told us that they found the staff to be supportive and very caring.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs and other staff if a patient was also a carer. We were told that access to appointments was flexible to patients who were carers. We were also told that the GPs and services were flexible and home visits to those patients who needed them in order reduce the difficulties some carers had in attending the practice.

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 had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example, the higher than average elderly population living in remote areas meant that GPs routinely provided a more expansive home visiting service and also provided a domiciliary phlebotomy (blood testing) service.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request, this included patients requiring home visits. There was also triage service so that urgent requests were assessed and prioritised according to need.

The staff and the practice had a very flexible approach to providing support to patients and to the community surrounding the practice. This was evident from the response the practice took when the local community around them was devastated by flooding in 2014. We saw information which showed they had provided healthcare services for their own and other GP practices in the area during this period of time. The practice had set up weekly services in a church and carried out home visiting. They provided a dispensing and medication delivery service in conjunction with the assistance from the emergency services. Much of this work and support was carried out by the practice staff and their supporters using boats or other methods of transport.

There was a computerised system for obtaining repeat prescriptions and patients were gradually using the email request service. The email request service allowed patients to ask for repeat prescriptions electronically. Other patients either posted or placed their request in a drop box in reception. 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. Representatives from the PPG said the practice listened to them and also to the comments patients made about the service.

Tackling inequity and promoting equality

The practice had recognised they may need to support people of different groups in the planning and delivery of its services. Such as people whose first language was not English They had identified that they met the majority of the patients' needs they currently provided a service for. Patients had access to online and telephone translation services should these be required.

The premises had been built and adapted to meet the needs of patient with disabilities. Patient areas were all on ground floor level, the extension built in 2010 was accessible and suitable for wheel chair users and people with limited mobility. We saw the practice had assessed the environment in July 2014 to see if it met patients, staff and visitor's needs. They had involved the PPG in this assessment to check if the practice was disability friendly. The group had made recommendations and we saw these recommendations were included in the environmental risk assessment and a plan had been set to address these recommendations by the practice management. For example, the doors in the entrance area were seen as too heavy to manage independently by a wheel chair user and an electronic opening system was suggested to ease the problem.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and patients with prams and allowed easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities.

Access to the service

The practice telephone was open to patients from 8am to 6:30pm. The practice was open from 8.30am to 7.20pm on Monday and 8.30am to 7.10 on Tuesday and Wednesday. On Thursday and Friday each week the practice closed at 6.30pm. The practice had appointment only access for patients on Saturdays from 8.00am to 11.00am. The practice referred patients to another provider for an out of hour's service to deal with any urgent patient needs when the practice was closed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice website, these were also on display in the practice waiting areas and are 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 the telephone number they should ring and provided information on the out-of-hours service.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally 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 make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Information was on display in the patient areas and included on the practice website. There were leaflets provided for patients to take away if they wished to with details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. Patients we spoke with were aware of the process to follow if they wished to make 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 14 complaints the practice had received in the last 12 months and found generally they were satisfactorily handled and dealt with in a timely way. The complaints ranged from a variety of issues, some were comments made by patients which were handled as a complaint but on examination these were more issues of understanding by patients about what services the practice was able to provide. We saw that from all complaints the practice had looked at how it could improve and avoid patients raising similar complaints in the future.

There was a method to identify common areas of complaints. Each complaints or comments were also reviewed. Where potential serious concerns had been identified these were elevated as an significant event and then reviewed in more depth by the management team.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients The practice felt it was important, as a training practice, to train and develop GPs for the future and that is was equally as important to provide an up to date service to the patients they support.

When we spoke with five of the GPs, the nurse practitioner and one practice nurse they all understood what the vision and values of the practice. We heard how they had valued the caring ethos at the practice and how this was reflected by their colleagues and staff team. There was an enthusiastic approach to providing teaching, training and support to all levels of staff. We also spoke with the locum practice manager and the reception and administration staff on duty; they all expressed the same opinion about the caring supporting ethos of the practice.

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. Staff were required to record when they had read and understood new or reviewed policies and procedures. 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, the handling of vaccines and medicines or ensuring a consistent approach was made for patient referrals.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. One GP took the lead for clinical governance, and another led the support for the trainees at the practice. All of the members of staff we spoke with were all 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. The QOF data for this practice showed it was performing above or within line with national standards. We saw that Quality Outcomes Framework (QOF) data and information from the Somerset Practice Quality Scheme was regularly discussed at monthly team meetings and plans were put in place to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, reviewing how combinations of specific medicines were used and how this impacted on aspects of patients' health.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as the environment. We saw that the risk log was reviewed and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held monthly governance meetings and business meetings where issues were discussed and plans put in place to develop the service.

Leadership, openness and transparency

We heard from staff at all levels that team meetings were held regularly, at least monthly. 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. Salaried and trainee GPs were included in partner meetings and this was reflected in the conversations we had with them where they felt included and valued in the running and development of the service.

The practice employed a locum practice manager whilst it was in the process of recruiting and employing a new practice manager. We heard how the current member of staff in this role had continued to ensure all aspects of managing the service were carried out effectively. This included being responsible for human resource policies and procedures and their implementation. We reviewed a number of policies, such as those for employing and supporting new staff and found they were up to date and had the required information. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient surveys and

Are services well-led?

Good

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

saw that patients had highlighted a range of issues that they thought could be improved. This included providing better information about appointments and services at the practice. The practice looked at improving the information on their website to offer greater clarity and produced a detailed leaflet to be provided to patients.

The practice had an active patient participation group (PPG) that had been in place for approximately four years. The PPG group age and ethnicity was representative of the population groups registered at the practice. The PPG had carried out annual surveys and met every two months. We met and spoke with two representatives of the PPG (Friends of Langport) who told us about the work they had done and how the practice had listened and responded to the questions they raised and the feedback they had provided. They told us they had been included in activities at the practice such as health promotion events and the promotion of the influenza vaccination clinics.

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 in the staff handbook and 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.

The practice was a GP training practice; it also provided practical experience for medical and nursing students. There was a focus on the development of individuals and involvement in research projects, the aim was to provide an up to date service to the patients registered with them.

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