Langport Surgery

Quality Report

North Street
Langport
Somerset
TA10 9RH
Tel: 01458 250464
Website: www.langportsurgery.co.uk

Date of inspection visit: 14 March 2018
Date of publication: 25/05/2018

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Key findings

Contents

Key findings of this inspection

Page

Letter from the Chief Inspector of General Practice 2

Detailed findings from this inspection

Our inspection team 4

Background to Langport Surgery 4

Why we carried out this inspection 4

How we carried out this inspection 4

Detailed findings 6

Action we have told the provider to take 19

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

(Previous inspection November 2014 – Good overall)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Langport Surgery on 14 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice participated in a local quality framework, Somerset Practice Quality Scheme (SPQS), rather than the national Quality and Outcomes Framework (QOF), to monitor practice performance and outcomes for patients. This meant that quantitative QOF data for 2016/17 indicated some patient outcomes were below average compared to the national average. However, SPQS information provided qualitative evidence of improvements in some areas of patient care; and examples of positive feedback from patients as a result of different ways of working.
- The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy. Arrangements for dispensing medicines at the practice kept patients safe. However, arrangements for medicines management did not ensure the security of blank prescription stationery.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.

Summary of findings

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a focus on continuous learning and quality improvement at all levels of the organisation.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way for patients.

The areas where the provider **should** make improvements are:

- Review arrangements for addressing safety alerts to ensure there is a record that all are received and that all actions are completed.
- Review arrangements for infection prevention and control (IPC).
- Review arrangements for recording training to ensure a record of all completed training is included.
- Review arrangements for the security of medical records to ensure unauthorised access is prevented.

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

Langport Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector supported by a GP specialist advisor.

Background to Langport Surgery

Langport Surgery is situated in the rural town of Langport, Somerset. The practice supports approximately 12,650 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. The practice is located in purpose built premises on one level, providing easy wheelchair access.

The practice provides services through a general medical service (GMS) contract with Somerset Clinical Commissioning Group. The practice is able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.

Regulated Activities are provided from one location:

Langport Surgery

North Street

Langport

Somerset

TA10 9RH

The practice age profile of patients is consistent with local and national profiles, with slightly higher proportion of patients aged over 65 years (29% compared with the local clinical commissioning group average of 24%); and both male and female life expectancy were consistent with local averages. The index of multiple deprivation placed the practice in the seventh decile (the fourth least deprived classification). 1.2% of patients were from black or minority ethnic (BME) groups.

The practice consisted of five GP partners, four male and one female; and a self-employed associate GP. The GPs were supported by two nurse practitioners and an urgent care paramedic; a team of five practice nurses, three Health Care Assistants (HCAs) and an apprentice HCA. The practice was a training practice with up to two GP trainees at any one time. The dispensary has a manager and a lead dispenser, supported by a team of dispensers and dispensary assistants. The clinicians were supported by a practice manager, office manager, finance officer and reception and administration teams.

The practice was open from 8.30am to 6.30pm Monday to Friday and to 7.30pm each Wednesday; with phone access from 8am to 6.30pm each weekday. Improved access arrangements were available, in conjunction with other local practices, providing appointments at extended times, up until 8pm Monday to Friday and on Saturday mornings. When the practice was closed patients could access an out of hour's service via NHS111.

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.

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) 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 GPs, members of the nursing team, the practice manager and reception and administration staff on duty. We visited and met with staff employed in the dispensary. We spoke with representatives of the patient participation group (PPG) on the day; and received information from a CQC comment card completed by a patient.

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.

Requires improvement

Are services safe?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). However, these arrangements should be reviewed to ensure the policy is comprehensive; and the completion of audit actions is recorded. For example, we saw that the policy did not include reference to management of outbreaks of communicable diseases; or reporting of notifiable infections to Public Health England. We saw that IPC audits had been completed in January and March 2018 and actions identified. However, there was no record to confirm that actions were completed. We spoke to the practice who provided, within 48 hours of the inspection, evidence that the policy had been revised and included relevant topics; and a spreadsheet confirmed that identified actions had been completed and by whom.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. We saw that the clinical records were of a high standard being very clear and detailed; and treatment escalation plans were in use.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and

equipment did not consistently minimise risks. However, we found that the practice did not ensure that prescription stationery was kept securely and did not monitor its use. This did not ensure care and treatment was provided in a safe way for service users. For example, whilst bulk supplies of blank stationery received were kept securely, there was no arrangement to record serial numbers of blank forms issued to GPs; blank forms were not held securely when clinical rooms were not in use; and there was no system to audit stocks of blank forms. We spoke to the practice who, within 48 hours of the inspection, implemented a prescription security protocol and associated records for blank prescription stationery.

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- We looked at a sample of six patients prescribed high risk medicines and found that for five patients reviews had been carried out to ensure safe use. However, for one of three patient records relating to one medicine there was no record found of blood tests since 2016. We spoke to the practice who, during the inspection, reviewed arrangements for management of patients on this medicine and followed up the patient concerned. Within 48 hours of the inspection the practice provided evidence that an updated policy for patients on long term medication had been implemented, including monthly searches and follow ups to ensure all relevant patients are regularly reviewed.

Dispensing services

- The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy. Arrangements for dispensing medicines at the practice kept patients safe.
- The practice has signed up to DSQS which rewards practices for providing high quality care to their dispensing patients. There was a named GP responsible for the dispensary. Staff involved in dispensing medicines had received appropriate training or were supervised while they completed their training. Annual competency assessments were completed by the lead GP for the dispensary.
- The dispensary carried out regular medicines audits including one looking at monitored dosage systems (blister packs) and the safe repackaging of medicines.
- Medicines were stored securely with access restricted to authorised individuals. Fridge temperature checks were completed daily to ensure medicines were kept at the appropriate temperature. Staff were aware of the process to follow if the temperatures went out of range.
- Repeat prescriptions could be ordered by patients by telephone, online, in person and by fax. When medicines needed a review, a GP would need to authorise the medicine before a prescription could be issued.
- Prescriptions were signed before medicines were dispensed and handed out to patients. A bar code scanner was used to check the dispensing process in addition to a second check by a dispensary staff member. The dispensary also offered patients weekly blister packs to support them to take their medicines.
- The standard operating procedures (SOPs are written instructions about how to safely dispense medicines) had been signed by dispensary staff and were reviewed annually.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored securely and access was restricted to appropriate individuals. Suitable arrangements were in place for the destruction of controlled drugs.
- Dispensing incidents and near-miss errors were recorded. Staff demonstrated how changes had been made to the dispensary process following a significant event analysis to minimise the chance of similar error reoccurring. For example, an error had occurred regarding dispensing of a controlled drug and process improvements had been implemented. We saw that the amended process included more detailed checks; patients affected had received apologies; and the learning from the event had been shared with all staff.
- Adequate systems were in place to deal with medicines alerts or recalls in the dispensary.
- Emergency medicines were easily accessible to staff and were checked regularly to make sure they were in date and safe to use.

Requires improvement

Are services safe?

- Patient Group Directions (PGDs) were in place to allow nurses to administer medicines. (A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Authorised staff had been assessed as competent to use them and the directions were up to date so patients were treated safely.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, we looked at the log of eleven significant events that occurred in the last year and saw evidence that action had been taken, learning identified and shared.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. However, there was no overall log of non-dispensary alerts to ensure checks could be made that all had been received; and no consistent recording that all actions are completed. We spoke to the practice who, within 48 hours of the inspection, provided evidence that the policy on alerts had been updated and a log was in use to enable regular checks that all alerts had been received; and record action taken and by whom.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice used technology to support patients' independence. For example, patients who requested assistance with self-help to address pre-diabetes and obesity could access a digital diabetes prevention programme (DDPP). This provided self-help via a digital device worn by the patient; and on-line advice via a smartphone app.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group prescribing (STAR PU) data was comparable to other practices.
- The number of antibacterial prescription items prescribed per Specific Therapeutic prescribing (STAR PU) data was comparable to other practices.
- The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones (less recommended anti-biotics) was comparable to other practices.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication. Through the Somerset Practice Quality Scheme (SPQS) reported for 2017/18, we saw increased numbers of patients coded as severely frail; increased numbers of patients with completed Fall Risk Assessment Tool (FRAT); and more action being taken based on the FRAT results for these patients.
- We also saw evidence through the SPQS of benefits to patients regarding bone health. For example the number of older patients screened for osteoporosis using the Fracture Risk Assessment (FRAX) Tool, resulting is suitable medicines being initiated.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. Through the SPQS the number of patients who had treatment escalation plans had increased.

People with long-term conditions:

- Through the Somerset Practice Quality Scheme (SPQS), we saw evidence of an increase in the number of patients diagnosed with hypertension and improvement in the rate of control. Patients could access 'Click Into Activity' (CIA) scheme that provided a one-to-one, face-to-face opportunity to meet specialist staff and receive advice on conditions such as hypertension and obesity.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. We saw that the practice had adopted the House of Care framework for long term condition care. This is an NHS England initiative that promotes a holistic, person centred approach to patients' care and their lives to help them achieve the best outcomes possible.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above standard for the target percentage of 90% or above, ranging from 92.4% to 95.9% for the four vaccination indicators.
- The practice also participated in a research study regarding the safety of intranasal flu vaccine for children

and adolescents. The findings may help to determine if there have been any change in the frequency or severity of any side effects compared to previous year's vaccinations.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 84%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to search for eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice participated in a research project to identify and provide diagnosis of early osteoarthritis. This may benefit patients through improved long-term clinical outcomes and reduced costs of treatment.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice had adopted the Gold Standard Framework to ensure coordinated care for patients on the palliative care register.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. We saw that there was a nominated member of staff responsible for ensuring patients with a learning disability were invited for annual reviews and followed up any non-attenders. We saw work was ongoing to support those patients who had most difficulty in attending due to the severity or complexity of their condition.

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

- The practice participates in Quality and Outcomes Framework (QOF).
- We saw evidence, through the SPQS, of initiatives implemented to support this patient group. For example, we saw the use of a Dementia Quality Toolkit that identified patients with clinical coding which suggested dementia but who were not on the dementia register.
- We saw that through the local 'CLICK' federation with other practices patients were receiving home visits by a pharmacist, emergency care practitioner and/or village agent. This supported patients with poor mental health to address both medical and social issues.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, we saw annual audits carried out to monitor clinical performance of care for patients with diabetes and osteoporosis; and the implementation of a new policy to improve care for patients with urinary tract infections.

Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice manager chaired the local 'CLICK' federation of practices which had been active in establishing joint employment of emergency care practitioners, home visiting pharmacists; a complex care GP; and in offering improved access to patients across the locality.

The practice participated in a local quality framework, Somerset Practice Quality Scheme (SPQS), to monitor practice performance and outcomes for patients, rather than the national Quality and Outcomes Framework (QOF is a system intended to improve the quality of general practice and reward good practice). This meant that quantitative QOF data for 2016/17 indicated some patient outcomes were below average compared to the national average. The most recent published QOF results were 58% of the total number of points available compared with the clinical commissioning group (CCG) average of 74% and national average of 95%.

However, SPQS information provided primarily qualitative evidence of improvements in some areas of patient care; and we found examples of positive feedback from patients as a result of different ways of working, as reported in relation to the population groups.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. However, we found that not all training completed had been recorded in the training record. For example, we saw evidence that staff had attended training in infection prevention and control and sepsis but that relevant dates were not included in the training spreadsheet. The arrangements for recording training should be reviewed to ensure a record of all completed training is included.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Regular multi-disciplinary case review meetings were held to discuss the care for patients on the palliative care register.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- New cancer cases were referred using the urgent two week wait referral pathway, in line with the performance of other practices.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. We saw that through the 'CLICK' federation of local practices, patients were supported to access social prescribing services to address social as well as medical needs. For example, village agents worked with patients and referred to relevant support groups to encourage healthy lifestyles.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- One patient Care Quality Commission comment cards was received and it was positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 222 surveys were sent out and 131 were returned. This represented about 1% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 97% of patients who responded said the GP gave them enough time; CCG - 94%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 89% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 89%; national average - 86%.
- 95% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 97% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 95% of patients who responded said they found the receptionists at the practice helpful; CCG - 90%; national average - 97%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. For example, patients acting as carers were identified when bringing other patients to the surgery and through the work of village agents, emergency care practitioners and pharmacists during home visits. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 494 patients as carers (4% of the practice list).

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. We saw a detailed carers' pack including a specific practice leaflet for carers with named carers' champion within the practice along with contact details for other local carers' support workers.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent

them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 93% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 83% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 85%; national average - 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, through offering extended opening hours, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments.
- The practice offered dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy. This provided easier access to medicines in the primarily rural area supported by the practice. Some patients were able to access home deliveries of their medicines.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, home visits were available from a range of professionals including pharmacist, urgent care practitioner and village agent, in addition to more traditional GP visits.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- Through the 'CLICK' federation with other local practices, village agents provided support to patients on social and healthcare issues and we saw positive patient feedback showing beneficial impacts on patients' physical health and mental wellbeing.
- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme. Through the 'CLICK' federation patients were supported by a specialist complex care GP. We saw that this provided enhanced level of GP input and clinical support resulting in improved patient outcomes. For example, patients in care homes received comprehensive reviews and advice and there was evidence of a reduction in avoidable hospital admissions.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Since 2013 the practice has participated in the national diabetes audit to monitor overall performance and identify any gaps; and carried out annual reviews of patients with osteoporosis/osteopenia to ensure patients were taking appropriate medicines and identify those at risk of fragility bone fractures.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We saw that a young people's information leaflet had been developed by the practice to introduce them to managing their own healthcare.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- We saw that men and women's health events were held at the practice for patient education on health topics.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- We saw evidence that close relationships were in place with local care homes with a lead GP providing regular contact and support to patients.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

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

- Village agents supported patients who needed help to organise some social aspects of their lives which in turn had positive impacts on the patients' health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. We saw that staff awareness had been improved through training and discussion at practice meetings, including for example external speaker from the Samaritans.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.
- Improved access to appointments on weekday evenings and at weekends was available to patients through the 'CLICK' federation of local practices.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was in many indicators significantly better than local and national averages. This was supported by observations on the day of inspection.

- 93% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 83% and the national average of 80%.
- 89% of patients who responded said they could get through easily to the practice by phone; CCG – 77%; national average - 71%.
- 84% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 81%; national average - 76%.
- 92% of patients who responded said their last appointment was convenient; CCG - 85%; national average - 81%.
- 88% of patients who responded described their experience of making an appointment as good; CCG - 78%; national average - 73%.
- 77% of patients who responded said they don't normally have to wait too long to be seen; CCG - 62%; national average - 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Ten complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, we saw that the patient group 'Friends of Langport Surgery' had raised funds to install an automatic door for the main entrance to make access easier; and a text message system had been introduced to remind patients of appointments.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, we saw that a dispensing error relating to controlled drugs had been addressed effectively and learning had been shared with all staff. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

Are services well-led?

Good

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

There were clear and effective processes for managing risks, issues and performance with the exception of some aspects of medicines management.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints. However, arrangements for addressing safety alerts should be reviewed to ensure there is a record that all are received and that all actions are completed. The practice provided, within 48 hours of the inspection, evidence that an updated alerts protocol and log of actions taken had been implemented.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. We saw evidence of a structured approach to quality improvement, involving all staff. We saw documented suggestions by staff to improve, for example, clarity of information and forms and labelling of medicines for patients.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- However, we found that the arrangements for the storage of paper patient records was not secure and did not prevent unauthorised access. For example, records were stored in an area behind the reception, accessible via doors that were not lockable. We spoke to the practice who, within 48 hours of the inspection provided evidence that they had reviewed arrangements for the security of medical records and had obtained quotes to fit security locks to prevent unauthorised access to the notes storage area.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, we saw evidence that the practice collated information and feedback from a variety of sources including friends and family test, patient participation group, education and wellbeing events and social media.
- There was an active patient participation group and we saw examples of newsletters including clear responses to feedback.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. We saw evidence of structured, clear business planning and improvement arrangements involving all staff. A set of ten high impact actions had been identified with the aim of releasing time to be directed at patient care.

Are services well-led?

Good

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

These included, active signposting training for reception staff; establishment of an urgent care team; development of new consultation types with urgent and routine appointments separated; team development including expanding the skill mix within teams; and development of initiatives for social prescribing and healthy lifestyles for patients.

- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. **How the regulation was not being met:** There was no proper and safe management of medicines. In particular: • arrangements for the security of blank prescription stationery were not in place; and • not all patients on high risk medicines were appropriately reviewed. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.