Crewkerne Health Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
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 Crewkerne Health Centre on the 12 November 2014. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, members of the patient forum, interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice is rated as good. This was because we found the practice was good at providing caring, effective, responsive and well-led services. The practice were also good for providing services for all population groups. The practice required improvement for providing safe services.

Our key findings were as follows:

- The practice provided patients with a good triage system which enabled patients to see a GP within two days. Patients who wanted to see a preferred GP may have had to wait longer.
- Patients generally told us staff were respectful and compassionate towards them when they visited the practice.
- The practice had good communication with other services and health professionals to ensure patients received joined up care packages.

We saw several areas of outstanding practice including:

- The practice was involved in the programme called 'Productive General Practice' supported by NHS Improving Quality. This programme has now been completed and last year the practice had been voted the best practice to have gained the most from the projects set out of all 20 Somerset practices that had participated. They continue to use this approach in

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their practice. For example, prescription staff changed their working hours to increase the availability for patients to receive their prescriptions during busier times.

- The practice had established through the Joint Strategic Needs Assessment for Somerset that Somerset had a higher than national average adult obesity. The Clinical Innovations Group piloted a weight management project, which has now ended. The practice found this a successful pilot and has continued with weight management clinics. Approximately 95% of patients that attended these clinics lose the targeted weight.
- There was a proactive system for double checking all patients with chronic obstructive pulmonary disease had 'just in case' medicines prior to Christmas and New Year holidays.

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

Importantly, the provider must:

- Ensure actions are addressed promptly following audits and assessments, such as fire risk assessments and infection control audits, to ensure they protect patients from risks that could have been detected.
- Regularly carry out clinical audit cycles to evidence whether improvements had been made and the measure of patient impact since the previous audit and shared with the team and new protocols formed, where necessary.
- Ensure there is a formal process to ensure results and research from audits and incidents, such as medical emergencies are shared with the team for additional learning and where necessary form new practice protocols.

In addition the provider should:

- Ensure a risk assessment is completed so appropriate medicines to use on a home visit are contained within the home visit bag and consider where it is kept in the practice to ensure it is held securely.
- Ensure they have appropriate evidence to provide proof of identification when recruiting new staff.
- Inform patients of the confidentiality arrangements in the reception area to reduce them from being overheard when discussing personal information.
- Ensure information on complaints is easily available for patients to access.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were thorough enough but lessons learned were not communicated widely enough to support improvement. Although risks to patients were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, addressing areas for improvement identified following audits and assessments, such as for infection control and fire safety.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams. The practice relationships with their allocated nursing and residential homes had effective communication and prompt actions by GPs to meet patient needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

National GP patient survey data showed that patients rated the practice similar to other practices for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The needs of the local population were reviewed and engaged with the NHS England local area team and Somerset Clinical Commissioning Group (CCG) to secure improvements to services

Summary of findings

where these were identified. Patients told us they found it easy to make a same day appointment and the practice tried to provide continuity of care with patients seeing their own GP for routine appointments.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain could be made more available to patients. Evidence showed the practice responded quickly to issues raised, learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. However, actions identified should be addressed within an appropriate timescale. The practice proactively sought feedback from staff and patients, which it acted on. The patient forum was active. Staff had received induction, regular performance reviews and 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 patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, avoiding unplanned admissions. The top 2% of patients who had been identified were at risk of emergency admission at hospital had been visited or received face to face consultations. This was in order to set a care plan to reduce admissions. The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. Monthly meetings were held with the community team to discuss patients who required end of life care and their needs were discussed when required.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicine needs were met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care. There was also a proactive system for double checking all patients with chronic obstructive pulmonary disease had 'just in case' medicines prior to Christmas and new year holidays.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young patients who had a high number of accident and emergency (A&E) attendances. Immunisation rates were just below Somerset Clinical Commissioning Group average for most standard childhood immunisations. Patients told us children and young patients were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw the waiting area had a children's play area to entertain children whilst they were waiting for their appointment. We saw good examples of joint working with midwives and health visitors and regular meetings were held to discuss any children or families 'at risk'.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended hours were provided on Monday evenings where GP and nurse appointments were available. The practice was proactive in offering online services for repeat prescriptions and had a future plan to implement an online booking system for appointments. There was a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with a form of dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. They had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. All GPs were aware of the need to respond quickly to a mental health crisis and the local

Summary of findings

support available. GPs carried out regular reviews of patients with severe mental health problems. The practice had a counsellor attend the practice regularly to provide talking therapies work and they had regular contact with the GPs.

Summary of findings

What people who use the service say

We sought comments from 23 patients throughout our inspection. This included speaking to patients visiting the practice, speaking to members from the patient forum and gaining views through comment cards. We received 13 comment cards, which provided us with a mixed experience of the care received at the practice. During our inspection we spoke with ten patients in total; five patients who were visiting the practice and five from the patient forum. Three out of five patients visiting the practice were very complimentary about the practice. One patient commented about the consistency of care because there had been a number of changes including long term sickness of two of the GP partners over the past four years.

The patient forum was formed in 2011 and there were currently 10 members. They told us the practice was committed to improving patient care and included the patient forum in the decision making when changes were planned. They also spoke highly of the practice including saying they felt they received personalised care and were not treated like a number because GPs had their own patient lists.

The practice and patient forum had completed a patient satisfaction survey over the period of October to December 2013. They had received 333 responses from patients showing a result of 80% of patients rating they were either satisfied or very satisfied with the practice. The previous year the practice had received 95% satisfaction rate and the patient forum felt this could be in relation to two GP partners being absent from the practice. The survey showed 95% of GPs explained treatment well to patients. The patient themes found were consistency of GPs, patient understanding of telephone consultations and the type of questions receptionists asked when a patient called.

Prior to our inspection we reviewed other sources of information in respect to what the patient experienced with the service provided. This included NHS choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been four comments made about the practice in the last year. Two were positive and two were negative comments. These patients had praised the staff and had said they were less satisfied about the appointment system. The practice had not responded to these comments on the NHS choices website.

We also reviewed the national GP patient survey taken from patients from the periods of July to September 2013 and January to March 2014. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 137 patients had completed the surveys from the 255 sent. We saw 82% of patients surveyed said their overall experience of the practice was good with 90% of patients saying they trusted and had the confidence in the last GP with whom they spoke. We saw patients were less satisfied with not being able to get through on the phone and were not happy about being overheard in the reception area.

Areas for improvement

Action the service MUST take to improve

- Ensure actions are addressed promptly following audits and assessments, such as fire risk assessments and infection control audits, to ensure they protect patients from risks that could have been detected.
- Regularly carry out clinical audit cycles to evidence whether improvements had been made and the measure of patient impact since the previous audit and shared with the team and new protocols formed, where necessary.
- Ensure there is a formal process to ensure results and research from clinical audits and incidents, such as medical emergencies are shared with the team for additional learning and where necessary form new practice protocols.

Action the service SHOULD take to improve

- Ensure a risk assessment is completed so appropriate medicines to use on a home visit are contained within the home visit bag and consider where it is kept in the practice to ensure it is held securely.

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- Ensure they have appropriate evidence to provide proof of identification when recruiting new staff.
- Inform patients of the confidentiality arrangements in the reception area to reduce them from being overheard when discussing personal information.
- Ensure information on complaints is easily available for patients to access.

Outstanding practice

- The practice had established through the Joint Strategic Needs Assessment that Somerset had a higher than national average adult obesity. The Clinical Innovations Group piloted a weight management project, which has now ended. The practice found this a successful pilot and has continued with weight management clinics. Approximately 95% of patients that attended these clinics lose the targeted weight.
- The practice was involved in the programme called 'Productive General Practice' supported by NHS Improving Quality. This programme has now been completed and last year the practice had been voted the best practice to have gained the most from the projects set out of all 20 Somerset practices that had participated. They continue to use this approach in their practice. For example, prescription staff changed their working hours to increase the availability for patients to receive their prescriptions during busier times.
- There was a proactive system for double checking all patients with chronic obstructive pulmonary disease had 'just in case' medicines prior to Christmas and New Year holidays.

Crewkerne Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Crewkerne Health Centre

We inspected the location of Crewkerne Health Centre, Middle Path, Crewkerne, Somerset, TA18 8BX, where all registered regulated activities were carried out.

The practice serves approximately 11,400 patients and covers a five mile radius around Crewkerne in South Somerset. The practice also has 1000 patients living in Dorset registered with them.

The national general practice profile showed the practice has a large demographic of patients over the age of 55 years above the England and Somerset Clinical Commissioning Group (CCG) average, particularly between the ages of 65 to 69 years old. The practice is under national and CCG average for patients under 44 year olds. The practice is in the least deprived range for the area.

There were eight GP partners, six male and two female. Each week the GPs covered 49 sessions which is the equivalent to six and half full time GPs.

The practice had recruited a nurse practitioner in September 2014, who works four days a week. A nurse practitioner is an advanced practice registered nurse, who has completed an additional three years training to enable them to have an increased knowledge base, clinical expertise and decision making skills. This enabled the GP to see patients with more complex needs.

The nursing team consisted of four female practice nurses, equivalent to approximately three full time nurses. There were also three female health care assistants, equivalent to approximately two full time health care assistants.

The practice had a General Medical Service contract with NHS England. The practice referred their patients to another provider for out of hours services to deal with urgent 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

Detailed findings

- Is it well-led?

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients whose circumstances may make them vulnerable
- Patients experiencing poor mental health (including patients with a form of dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke with the Somerset Clinical Commissioning Group, NHS England local area team, Somerset Local Medical Committee and the local area Healthwatch. We carried out an announced visit on the 12 November 2014. During our visit we spoke with a range of practice staff including the practice manager, four out of the eight GP partners, the nurse practitioner, three members of the nursing team, a receptionist, secretary and two enquiries administrators. We spoke with the district nursing team which were based in the practice. We also spoke with one nursing home and two residential homes for older people as some people residing in these homes were patients at this practice.

We spoke with 10 patients including five patients who were members of the patient forum group and reviewed 13 comment cards where patients shared their views and experiences of the service prior to our inspection.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, reviewed updates from the National Institute for Health and Care Excellence and national patient safety alerts. Staff we spoke with were aware of their responsibilities regarding how to raise concerns, and knew how to report incidents and near misses. For example, a nurse was concerned about a vulnerable patient who was displaying signs of physical abuse. They had reported this to the GP who then dealt with this appropriately and informed the local authority safeguarding team. Practice staff told us there was an open environment for staff to report their concerns to the practice manager or GP partners.

We reviewed the significant events and complaints over the last year. We saw practice meeting minutes discussed these incidents and how the practice could improve service provision to prevent recurrence. Newsletters to staff were also used to provide another source of informing staff of new agreed protocols.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last year. Significant events were discussed during the weekly partners meetings and any relevant changes were fed back to staff through a monthly newsletter. Staff, including receptionists, administrators and nursing staff felt comfortable to raise an issue for consideration at the meetings and they felt encouraged to do so by the partners.

We saw evidence of action taken as a result of a significant event or a complaint. For example, an abnormal blood test result had been left on an absent GPs desk when the member of staff thought they were available. This could have led to delayed treatment and was treated as a significant event. The practice had now changed the protocol for staff receiving results and they now gave the GP the results in person only. This was disseminated to all staff through their October newsletter.

We found not all staff were aware of significant incidents that had occurred in the practice. For example, there had been a number of medical emergencies but not all staff were aware that these had occurred and learning from these incidents had not been formally shared to the whole team.

National patient safety alerts and latest national guidance updates were disseminated from the lead GP to relevant staff and then if relevant were discussed at GP and nurse meetings to decide on their approach and any changes to the service provided.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. We were told by one of the GP partners there were two GP leads for safeguarding, one for child protection and the other for the protection of vulnerable adults. The GP lead for child protection had received level three training and had disseminated this to the rest of the staffing team in a team meeting.

Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. We heard of an example when nursing staff had a safeguarding concern about a child and had escalated it to the lead GP for child protection. They were also aware of their responsibilities in raising a concern and how to contact the relevant agencies in working hours and out of normal hours. We heard in this example that the GP had contacted the external authorities to raise their concerns. All staff we spoke with were aware who these lead practitioners were and who to speak with in the practice if they had a safeguarding concern. It was evident in our discussions with a number of staff of all levels that concerns were reported even if they were lower level concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example, children who were subject of a child protection plan. GPs ensured risks to children and vulnerable adults were flagged on the patient record system. This enabled practice staff to be aware these patients may need additional support and monitoring.

We saw the practice had a chaperone policy and posters in the waiting area advertising the option to patients. Receptionists who chaperoned for patients had received training and appropriate criminal background checks.

Requires improvement

Are services safe?

Medicines management

There was a clear policy for ensuring medicines were kept at the required temperatures. We saw there was a record for daily monitoring of the refrigerator temperature. Practice staff knew the action to take in the event of a potential failure.

Processes were in place to ensure routine medicines were stock rotated, checked for expiry and suitable for use.

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they not were stored securely. The practice acted on this within 24 hours of the inspection and had moved the medicines into a lockable cabinet. Following the inspection the practice was also reviewing which treatment/consulting rooms would routinely need to be locked. For example, if they held vaccines or medicines in the rooms. If a risk was assessed then the rooms at risk would be secured at all times. The practice should reassess where it holds the GPs home visit bag. At the time of the inspection this was not held securely, although was held outside of the patient area.

Vaccines were administered by nursing staff using directions that had been produced in line with legal requirements and national guidance. We spoke with one nurse who told us they had received training in child vaccinations in the last three years. The computer system also flagged up when a child had not received a vaccination so it could be discussed when the child/parent next visited the practice.

A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as ensuring they were updated in the specific clinical areas of expertise for which they prescribed.

Acute and repeat prescriptions were computer generated and were authorised by the patients GP. Reminders were flagged on the system if a medicine review was required for patients whose prescriptions were out of date. This helped to ensure patient's repeat prescriptions were still appropriate and necessary. We spoke with three nursing and residential homes in which the practice had registered patients and they told us the repeat prescription process was efficient and urgent prescriptions were promptly addressed.

The practice did not hold any controlled drugs on the practice premises for patient use. If necessary controlled drugs were easily accessible from the pharmacy next door to the practice. We did note that one of the GP partners who was also an out of hours GP held controlled drugs for their out of hours role. They brought them onto the premises when they were working. They agreed after our inspection that they would be kept off site securely.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice had contracted cleaners who cleaned the main non-clinical areas of the practice and worked to an agreed cleaning schedule. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Patients mentioned the practice appeared tired and could do with new upgraded décor. However this did not affect the patient care provided.

The practice had a lead person identified for infection control. This person had not undertaken any further training since 2012, to enable them to provide advice on infection control and carry out staff training. The practice manager had arranged for their lead person to attend an updated infection control training course in December 2014 to enable them to cascade updated infection control training to all staff. We saw evidence the lead had carried out an infection control audit in July 2014 and improvements had been identified for action. However, these had not been addressed by the partners. We found some toilets, patients and staff and treatment rooms did not have the standard infection control equipment in, such as there were no pedal waste bins and soap and moisturiser dispensers. Following our inspection the practice had taken action to address the specific areas identified in the infection control audit.

An infection control policy and supporting procedures were available for staff to refer to. This enabled staff to implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. The disposable curtains were routinely changed on an annual basis or if there was evidence of a spillage. However, the practice had a plan in place to change the curtains every six months following current guidance. There was also a protocol in place if a needle stick injury occurred and procedures in place with the local hospital.

The practice had arranged for an external company to carry out a review on the practice, shortly after our inspection.

Requires improvement

Are services safe?

They told us they would carry out any management of legionella (a germ found in the environment which can contaminate water systems in buildings), where recommendations had been made.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. For example, a spirometer (which assists with the diagnosis of lung conditions), an electrocardiogram and blood pressure monitor. We saw all equipment had been tested and maintained in the last year. All portable electrical equipment was tested annually and displayed stickers indicating the last testing date. The practice did not have a schedule of testing in place. However, they told us all their equipment was usually maintained by the same company.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it should follow when recruiting clinical and non-clinical staff. We reviewed five recruitment records which contained evidence of recruitment checks that had been undertaken prior to employment. For example, references from previous employers, evidence of qualifications gained and evidence of registration with the appropriate professional body, where applicable. The practice had not retained a copy of proof of identification even though they routinely reviewed this through other checks carried out. They told us they would hold a copy with any future recruitment. All GPs, nursing staff and chaperones had criminal background checks through the Disclosure and Barring Service (DBS).

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included routine checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. There was an identified health and safety representative and they told us they had received training.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. For example, the possibility of a threat of challenging behaviour from patients. The practice had provided training to all staff on how to manage this type of situation effectively.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The practice held emergency medicines such as, medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of severe pain. The reason for this was because there was a pharmacy attached to the practice and so accessing these medicines would be relatively easy, if required.

We saw equipment and emergency medicines were kept in different areas of the practice. We were told this worked well for the practice and had experienced a couple of medical emergencies without a problem. Staff told us they all knew the location of the equipment and medicines.

Emergency medicines were not routinely held in a secure area of the practice. Following our inspection the practice was reviewing their practice protocols and ensuring medicines were kept securely. Processes were in place to check whether emergency medicines and equipment was kept within their expiry date and suitable for use. All the medicines and equipment we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a company to contact if the heating system failed.

The practice had carried out a fire risk assessment in October 2006 and last reviewed in March 2013. The suggested date for review was annually and so the policy was now out of date. We saw staff had received fire awareness training and fire equipment was maintained.

Requires improvement

Are services safe?

However, other actions raised had not been addressed. For example, the practice was not testing the fire alarms or completed a fire evacuation or drills to ensure staff understood their role in an event of a fire. Following our inspection the practice had addressed the issues described. However, there were still a number of actions to address, such as there was no emergency lighting as suggested, or a fire warden.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice had a lead GP who took the responsibility to disseminate new guidelines to other relevant staff. This was generally emailed to other staff and any critical updates were discussed at practice meetings. We found from our discussions with the GPs and nurses staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes and respiratory conditions and the practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs and nursing staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of end of life care. The district nursing team and a hospice palliative care nurse were invited to the GP partners meetings where latest guidance of end of life care was discussed to enable GPs to provide care following best practice guidance.

One of the GP partners told us they had a higher prevalence for diagnosing conditions such as hypertension, heart conditions, respiratory conditions and dementia in comparison to other practice's performance within the local Somerset Clinical Commissioning Group area.

The practice used computerised tools to identify patients with complex needs who had multi-disciplinary care plans documented in their case notes. All patients were allocated a named GP and this GP took responsibility for their patients care. All patients who had an avoiding unplanned admissions plan would be contacted within two working days of discharge by the practice.

We spoke with the medical secretary regarding the process for referrals. The computerised system highlighted urgent referrals initiated by the GP and these were always completed as a matter of priority and always by the end of the working day. There were arrangements in place when the medical secretary was not working to ensure referrals were addressed promptly. On average the GPs sent through 60 referrals to be completed each day and these were usually completed within 48 hours. We were told when an urgent referral was received this would be prioritised and confirmation of the referral was checked to ensure the hospital had received the referral.

We saw no evidence of discrimination when staff made care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

We saw nine clinical audits which had been undertaken in the last four years. One out of the nine audits was able to demonstrate the changes resulting since the initial audit. For example, an audit had been completed for patients with renal function conditions. The practice had found improvements had been made since the last audit due to increased GP knowledge on the subject and reduced medicines prescribed to patients. The audit was discussed at a clinical meeting with the other GPs to share learning.

We saw the practice audited their processes when they were informed of either new national or local guidance or audits that secondary care had undertook which had affected the patients at the practice. For example, a cancer diagnosis audit was completed in 2013 when two patients had been admitted to hospital and were diagnosed with cancer. The practice reviewed the patient's notes to establish if anything could have been improved for the patient to have an earlier diagnosis. The practice found no improvements were necessary. We found the practice often did not re-audit to see whether they had improved the impact on patient's impact since the previous audit. There should also be a formal process to ensure results and research from audits was shared with the team and formed new practice protocols, where necessary.

We saw a clinical audit had been carried out on medicines management in January 2013. For example, we saw an audit regarding the top 30 patients who were prescribed a high number of medicines and cost to the practice.

Good

Are services effective?

(for example, treatment is effective)

Following the audit, the GPs established these patients were on the most appropriate medicine prescribed and this was clarified by the patient's specialist, where necessary. This had also provided an opportunity to invite patients to attend the practice for additional tests that were outstanding.

The practice had opted out of the quality and outcomes framework and had joined other practices in Somerset to use the Somerset practice quality scheme. The scheme works to improve patient care, such as reducing hospital admissions, joined up working of practices to reduce duplication of work and improving long term conditions management. The practice was also part of a federation of eight practices within the local area, four of which were part of the Somerset practice quality scheme. This enabled them to share learning and joined up working within the community. They were currently working together in improving links with the community pharmacists.

There was a comprehensive protocol for repeat prescribing dated September 2014. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice was working towards the gold standards framework for end of life care. The practice had identified patients on the palliative care register and had monthly multi-disciplinary meetings to discuss the care and support needs of patients and their families. The district nursing team were based at the practice and they always attended these meetings including a hospice palliative care nurse. The majority of the GPs attended these meetings, which ensured a consistent approach to end of life care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors including four GPs with an additional diploma in obstetrics and gynaecology, four GPs with a diploma in family planning and one GP with a diploma in child health. All GPs were up to date with their yearly continuing professional development requirements and six out of eight had been revalidated and the other two 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example an administrator had progressed to a qualified health care assistant.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and stroke prevention and anticoagulation training. Those with extended roles who treated patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease told us they had appropriate training to fulfil these roles.

We were told of an example where poor performance had been identified appropriate action had been taken to manage this. Also, procedures had been changed to reduce the likeliness of the incident happening again.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. The practice received blood test results, X ray results and letters from the local hospital including discharge summaries and out-of-hours GP services updates both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was one incident within the last year where blood test results had not been followed up promptly. The receptionist had left the results on the GPs desk not realising they had left for the day. There was no impact on the patient but it highlighted the need to change the practice processes. The practice had reviewed their procedure and decided all urgent results should only be given in person.

Good

Are services effective?

(for example, treatment is effective)

The practice held multi-disciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or children on the 'at risk' register. The multi-disciplinary meetings held had attendance from other health care professionals such as district nurses, health visitors, midwifes and palliative care nurses along with the GP partners and nurses in the practice. Decisions made about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Prior to the inspection we spoke with three residential and nursing homes where the practice had patients. We received good feedback from all three who advised the communication between them and the practice was excellent. If there was urgent need for the GP to visit the patient then this was acted upon promptly.

The practice had developed an I.C.E card (In Case of an Emergency) for carers to complete and carry on them if they became ill. The card included information such as the carers, the person they were caring for and their next of kin contact details. This enabled the emergency services to be aware that this person cares for someone who was at risk without a carer. This had been developed approximately three years ago and because this had been successful, a local carers group had informed other practices in the area, who were now using the same approach.

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. Electronic systems were in place for making referrals, and the practice made the majority of the referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported this system was easy to use and they assisted patients, when necessary, to help support their decision making process for their referral. The practice has signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, 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 staff were aware of the Mental Capacity Act (2005), 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. When interviewed, staff provided examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Patients with a learning disability and those with a diagnosis of a dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit which reviewed minor surgery in 2011 and this confirmed the consent process for minor surgery had been followed in 98% of cases.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and Somerset CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. For example, obesity was a problem in the local area. A pilot for weight management was funded by the clinical innovations group and a healthcare assistant was trained and started the course for patients in the practice. This pilot had proved to be very successful for the practice and its patients on the course. The practice had decided to continue these courses as it had a 95% success rate.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a health check with the GP to all new patients registering with the practice, who had a health condition. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. The practice was due to start the NHS Health Checks to all its patients aged 40-75 and nursing staff had received their additional training.

The practice had numerous ways of identifying 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 and all 34 patients were offered an annual physical health check.

The practice's performance for cervical smear uptake was 79.2% and was slightly below local CCG area average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually.

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 child immunisations was just below average for 14 out of 16 immunisations in comparison to other practices in the local CCG area. There was a clear policy for following up non-attenders by the named practice nurse.

The practice has coordinated a 'fun flu day' for the past 12 years. This consisted of inviting eligible patients who would like a flu injection to attend at the local village hall. It was also an opportunity for local community involvement and raising money for charity. This year they had given 2000 patients flu injections and raised £3,700 for children in need. Over the last 12 years including this year they had raised a total of £40,000 for children in need.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP practice patient survey from 2013/2014 and a survey of 333 patients was undertaken by the practice's patient forum in October to December 2013. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed 82% of patients rated their overall experience of the practice was good. The practice was above the local Somerset Clinical Commissioning Group regional area for its satisfaction scores on seeing or speaking with a preferred GP.

Prior to our inspection patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and the majority of the comments were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Six comments were less positive and showed a theme of dissatisfaction in the lack of consistency of the GPs and the new appointment system. We also spoke with five patients; three out of five patients were very complimentary about the practice. Another patient had commented about the consistency of care because there had been a number of changes including long term absence of two of the GP partners over the past four years.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The main reception desk was within the waiting area. The national GP survey results showed 38% of 174 patients surveyed told us they were not happy with the level of privacy at the reception desk. The practice had tried to improve this by increasing the use of an area which was more private within the front entrance. Reception staff told us they could use the practice manager's office or a quiet part of the waiting area, if necessary. However, we did not see any evidence to inform patients of this service. We did see this area being used during the inspection. However, this was mainly used by patients requesting repeat prescriptions.

Telephone calls received by the practice were mainly taken away from the reception desk and calls received at reception were dealt with sensitively to ensure confidential information was not overheard. Receptionist computer screens had a privacy screen on them to ensure patients at the desk could not see personal information.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance of abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of patients said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were similar to the regional CCG average. The results from the practice's own satisfaction survey showed that 96% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They 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. The majority of patient feedback on the comment cards we received was positive and aligned with these views.

Good

Are services caring?

Staff told us translation services were available for patients who did not have English as a first language. We did not see any evidence of notices informing patents of this service in the reception area.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. The comment cards we received were consistent with patients spoken with. For example, they highlighted staff were caring and responded compassionately when they needed help and provided support when required.

One of the GP partners told us they had a trained carers champion and a registered dementia friend to provide further support to these patients.

Notices in the patient waiting room and on the practice website told patients how to access a number of support groups and organisations. The practice computer system alerted GPs if a patient had caring responsibilities.

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 patient's 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 in the way services were delivered.

We heard the practice engaged regularly with the NHS England local area team and Somerset Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements which needed to be prioritised. The practice was part of a federation of eight practices within the local area and was leading to improve links with community pharmacists.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient forum. For example, the GP partners wanted to recruit a nurse practitioner. They discussed this with the patient forum before recruiting to gain their view on whether this would be beneficial for the patient base.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had over 10% patient base aged over 75 years old. There were also 10% of patients who lived in Dorset the adjoining county, which had its own challenges for referring to secondary care in another clinical commissioning group area. There were a small percentage of patients registered with a diagnosed learning disability and a diagnosed form of dementia. The practice recognised and encouraged carers to register as a carer with them to enable the practice to provide additional support, when required.

There were a very small proportion of patients whose first language was not English. The practice had access to online and telephone translation services including a translation page on their website. We heard approximately 0.2% of patients registered were Polish. We noted information on antibiotic prescribing and chaperoning was displayed in Polish.

All staff had access to the equality and diversity policy within their staff handbook. Three staff had recently attended equality and diversity training in September 2014 with Somerset CCG.

The premises and services had been adapted to meet the needs of patients with a disability. The practice had automatic front doors to assist patients who used a wheelchair or patients with prams. There was a high and lowered reception desk so reception staff could easily speak with patients who were in a wheelchair. Patients who were hard of hearing could use the installed hearing loop at the reception desk. There were two types of chairs in the seating area for patients to choose from depending on their comfort and need. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. The practice had two dedicated disabled parking spaces for patients to use. All consulting and treatment rooms were situated on the ground floor of the building.

Access to the service

Appointments were available from 08:30am to 11:50am and 3:50 to 5:30pm on weekdays. There were also additional appointments available outside core surgery hours of pre-bookable and urgent same day appointment slots. The practice had extended appointments on Monday evenings from 6:30-7:15pm. Evening extended hours also had nurse appointments where family planning, health checks, cervical smears and weight management clinics were available for patients.

All patients were allocated a named GP and the practice tried to accommodate appointments with the patients preferred GP where possible. There had recently been a number of changes with the GP partners and so consistency of seeing the same GP had decreased. The practice was hoping this would improve over time whilst recruitment and stability of GPs improved.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. 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 depending on the circumstances. Clear information of the out-of-hours service was provided to patients on the practice website.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

visits were made to three local residential and nursing homes when required. One nursing home told us the named GPs always tried to visit individuals and often they would see two or three GPs from the same practice visiting their own patients. They also said if they requested an urgent visit often the GP would be there within 15 minutes of calling, to see the patient. The named GP would also provide health checks and flu vaccines or they would be completed by the practice nurse. The other two residential homes told us they often did not see the named GP but would always had a prompt response from the practice.

A new appointments system had recently been implemented. Patient calls for appointments were now triaged by a GP or nurse practitioner so patients could be prioritised and allocated an appropriate GP or nurse. This new system wanted to ensure where patients in need were seen the same day. Patients were generally satisfied with the appointments system. They confirmed they could see a doctor on the same day if they needed to. For example, a patient told us they had called the same day for their child and they had been provided with an appointment after school hours, so the child could be seen without missing school. Patients commented seeing the GP of their choice for a routine appointment had a reasonably long time of approximately three weeks.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. We read the complaints policy and saw it had been reviewed in the last year. The complaints procedure for patients was in line with recognised guidance. There was a designated responsible person who handled all complaints in the practice.

We did not see any information was available to help patients understand the complaints system within the practice. Patients were expected to ask receptionists for the complaints procedure/leaflet or speak with the practice manager. The practice website had information on how to complain internally but did not explain how patients could complain externally if they did not want to directly complain to the practice. Patients we spoke with were not always aware of the process to follow if they wished to make a complaint.

We saw there had been 23 complaints received in the last 12 months. We saw the practice had acted on complaints and learned from them. For example, a patient wanted to discuss a sensitive issue at the reception desk, the receptionist did not pick up this and so the patient had to discuss this issue in front of others. The patient complained and receptionists were reminded that if a patient seemed reluctant, then they could ask the patient to write down what they wanted so other patients would not overhear.

The practice reviewed complaints annually to detect themes or trends. We read the report for the last review and noted that patient complaints had been related to GP and nurse changes and absence. We saw lessons were learnt from individual complaints.

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 vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were displayed in their practice leaflet. The practice vision included providing the best possible service and ensuring there was a good partnership between patients and practice staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We read 11 of these policies and procedures and we saw they had been reviewed annually and were up to date. Except the complaints policy did not reflect the same information as the complaints leaflet provided to patients.

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 two GP partners were the lead for safeguarding, one for child protection and the other for vulnerable adults. We spoke with 13 members of staff and they 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 had an on-going programme of clinical audits which was used to monitor quality and systems to identify where action should be taken. They had completed nine clinical audits in the last four years. It was noted that clinical audits cycles were not always completed. For example, an audit had been completed for atrial fibrillation in 2013. New National Institute for Health and Care Excellence guidelines had been published in June 2014 and a new audit had not been completed to establish if their practices reflected new guidelines.

The practice had robust 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 trip and electrical hazards. Risk assessments had been carried out where risks were identified and action plans had been produced however they were not always implemented. For example, an infection control audit had been completed in June 2014 with a number of actions, such as pedal bins and wall mounted soap dispensers were required. However, we noted none of these actions had been addressed. Within 24 hours of our inspection the practice had informed us they had ordered these items detailed above and devised an action plan which will be discussed with the GP partners on the 4 December 2014.

The practice held monthly governance meetings with the GP partners. We looked at minutes from the last two meetings and found that performance and quality had been discussed.

Leadership, openness and transparency

The practice had a number of meetings throughout the year for its staff groups. We saw administration and reception staff had two meetings a year, the GPs had weekly meetings to discuss patient risks, the nursing team met every six to eight weeks with a GP to discuss nursing procedures. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment and staff induction policies, which were in place to support staff. We were shown the electronic staff handbook which was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The practice was involved in the programme called 'Productive General Practice' supported by NHS Improving Quality. This programme has now been completed and last year the practice had been voted the best practice to have gained the most from the projects set out of all 20 Somerset practices that had participated. They continued to use this approach in their practice. The practice had changed a number of things to their practice during the completion of the programme. For example, prescription staff changed their working hours to increase the availability to patients during busier times. There was now a daily break organised for GPs to meet during the day to discuss any issues and improve communication between the team.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, the patient forum, comments and

Are services well-led?

Good

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

suggestions made and complaints received. We read the results of the annual patient survey carried out from October to December 2013. The main themes from the survey were satisfaction and dissatisfaction with the telephone consultations, lack of continuity of care due to GP partner absence and concerns about reception staff asking patients for more information about their medical urgency. The patient forum and practice staff met to discuss the findings and agreed actions to improve patient satisfaction. For example, improving patient knowledge of the new appointment system by improving the questions staff asked to patients when they phoned for appointments, produced an information flowchart for patients on appointments and more information for patients in the waiting area, patient leaflet and website on urgent appointments.

The practice had an active patient forum which had approximately ten members and had ten meetings a year with the practice. The forum actively supported the practice in gaining views from patients. For example, the recent survey carried out, forum representatives were present at the practice flu day at the local village hall, where they encouraged patients to complete the survey. They also had a virtual patient group of 175 members, who were sent surveys to complete to gain their views on the services provided. The results and actions agreed from these surveys were available on the practice website.

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. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We read five staff files and saw regular annual appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had opportunities to develop such as a receptionist had been promoted and was training as a health care assistant.

The practice had completed reviews of significant events and other incidents but had not always shared with all staff to ensure the practice improved outcomes for patients and learned from each other. For example, medical emergencies had occurred in the practice but not all staff were aware they had happened and so learning had not been shared with the whole team.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider must ensure they address actions identified following audits and assessments, such as fire risk assessments and infection control audits, to ensure they protect patients from risks that could have been deterred. The provider must ensure they regularly carry out clinical audit cycles to evidence whether improvements had been made and the measure of patient impact since the previous audit and shared with the team and new protocols formed, where necessary. (Regulation 10 (1))