Bruton Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection visit to The Bruton Surgery on 11 November 2014. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, responsive and well led services. It was good for providing an effective and caring service.

Our key findings were as follows:

- Patients had their needs assessed and were provided with the care and treatment they needed.
- Patients had access to appointments with their named GP and were always seen if their need was urgent.
- Patients' voices were listened to and acted upon.
- Patients were treated with dignity and respect
- Patients were provided with continuity of care and ensured that patients with long term health needs were met.

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

Importantly, the provider must:

- Improve the management of medicines and emergency equipment to ensure the safety of patients and staff.
- Improve quality assurance processes to ensure emergency equipment is fit for purpose, infection control systems are in place and actions taken to minimise the risks to patients and staff.
- Ensure their recruitment processes include a risk assessment to identify where a Disclosure and Barring Service check is required.

In addition the provider should:

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- The practice should monitor and implement actions to ensure the practice environment is accessible to patients or staff with limited mobility or wheel chair users.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Patients were at risk of harm because systems and processes were not in place or were not implemented in a way to keep them safe.

The small amount of medicines used at the practice were kept in an unlocked cupboard in the treatment room.

In the staff files and training records we looked at there was no evidence of any recent training for the lead practice nurse or for any of the clinical staff in respect of infection control. We saw that an infection control audit had been carried out on 5 November 2014 we saw from this audit that there were a number of issues and concerns identified including poor hand wash facilities and unsuitable flooring. No action plan or risk assessments had been put in place to ensure improvements were made. We were informed that details plans had been agreed to upgrade the nurses' treatment room which would address some of these issues.

There were no risk assessment process in place for those staff without a criminal records check through the Disclosure and Barring Service (DBS). We saw that there were some aspects of the environment, such as disability access, that were not routinely reviewed or risk assessed. There was a system and records of safety checks for the emergency equipment. However, the checks failed to identify emergency medicines were stored in a box that was not fully secure. Other emergency equipment guidance on their safe use was not recent and may not be accurate and up to date.

The storage and safety of oxygen at the practice was unsafe. We found the cylinder unsecured. The cylinder was not in a trolley or chained to the wall to prevent it falling. There was no signage outside the door to alert the emergency services and public that oxygen was stored in the room.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Staff had been trained at the appropriate level to be able to recognise and respond to concerns of possible abuse or harm for children and vulnerable adults.

Summary of findings

Are services effective?

Good

The practice is rated as good for providing effective services. We were told that one GP took the lead on reviewing, summarising and ensuring information was disseminated to staff. We heard about practice meetings where new guidance was discussed and actions developed to implement these.

Information from the Quality and Outcomes Framework (QOF) (QOF is a national performance measurement tool) in regard to patients with respiratory disease, diabetes, chronic heart disease, or poor mental health showed the practice was a high performer (99.6%) during 2012/2013 in meeting these QOF indicators. The practice opted out of QOF during 2013/2014 to participate in the local Somerset Clinical Commissioning Scheme and therefore they were not able to provide information relating to that period.

We were told about the work the practice did with other health providers and practitioners. Health visitors met for regular clinics at the practice. The community district nursing team had access to the practice in order to update and manage their patient records.

The practice also offered 'well women' and 'well men' health checks. Health advice and support was given when patients attended appointments for areas such as smoking cessation.

The practice kept a register of all patients with learning disabilities and patients with a diagnosis of requiring mental health treatment and offered them an annual physical health check. There was a method of identifying special groups of patients such as those receiving end of life care and those over 75 years of age. Staff undertook testing for memory and dementia screening with older patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Information from the NHS GP patient survey from 2013 showed patients had experienced their GP was good or very good at treating them with care and concern. Patients rated it at 93% which was above the national average of 85% in this area. One patient told us how much they had appreciated the support given as a family when

Summary of findings

serious ill health had occurred with a member of the family. This person told us that they had found the named GP had fully understood their relatives' needs and provided both emotional and practical medical support.

The practice had a carer's champion, an identified member of staff to assist and signpost carers to additional help and support. We saw from the latest newsletter issued by the Patient Participation Group (PPG) carers' were provided with information about a local befriending service and access to carers groups. The practice hosts a 'talk and support' twice a week for carers at the practice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The outcomes had resulted in changes to the methods of repeat prescription requests by installing a 'drop box' for repeat prescriptions in August 2013. The lack of identity badges for staff had been addressed in January 2014.

The practice had identified difficulties with meeting disabled patient's needs in regard to access to the premises and had put alternative arrangements in place to meet some of these needs until they could be fully addressed. The practice had implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a clear vision and strategy. When we spoke with staff it was evident the practice had high value placed on continuity of care for all their patients.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff told us they felt supported by management. The structure identified named members of staff in lead roles. For example there was a lead nurse for infection control and two of the GP partners were the leads for safeguarding, one for adults another for children. The practice manager was supported by a GP partner in responding to and acting upon any complaints made to the practice.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. However, there were

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gaps in the systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings 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

Requires improvement

The practice is rated as requires improvement for the care of older people. Unplanned admissions and re-admissions to hospital for older people were regularly reviewed with input from the district nursing team and improvements made to their care to prevent reoccurrence. Patients from this group had a care plan in place to identify potential risk and eliminate them. Staff were alerted to patients at risk on the electronic patient records so that they could respond appropriately and alert GPs or practice nurses as soon as possible to concerns.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice, the management of the control of infection and a risk assessment process when recruiting staff.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. There was a repeat prescribing policy which gave details of the practices processes including the requirement for regular reviews of patients on long term treatment. For example patients with respiratory disease, diabetes, chronic heart disease, or poor mental health. We saw from information provided by the practice that previous history showed the practice was a high performer (99.6%) during 2012/2013 in meeting the QOF indicators for people with long term conditions. GPs and nursing staff were involved in the regular monitoring of patients health care needs. Patients we spoke with confirmed that regular checks were offered and provided to them.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice, the management of the control of infection and a risk assessment process when recruiting staff.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. Children at risk were identified and concerns were discussed with other service providers or practitioners such as health visitors.

Summary of findings

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Staff sign-posted young people towards sexual health clinics and offered confidential testing packs for sexually transmitted infections. The practice told us they had recognised they needed to develop further the support they provided to young adults in providing sexual health guidance at the practice.

The practice hosted visiting health visitor and midwives for regular clinics at the practice. The district nursing team were provided with access at the practice with computer links to update and manage their patient records.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice, the management of the control of infection and a risk assessment process when recruiting staff.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The practice offered 'well women' and 'well men' health checks. Health advice and support was given when patients attended appointments for areas such as smoking cessation.

The practice had recognised the needs of different groups in the planning of its services. It was able to offer extended hours after the practices usual opening hours regularly each Monday and alternate Tuesday evenings for those who were unable to attend during the usual working day.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice, the management of the control of infection and a risk assessment process when recruiting staff.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies.

Summary of findings

Patients with learning disabilities were supported to make decisions about their care.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice, the management of the control of infection and a risk assessment process when recruiting staff.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Patients with poor mental health had care plans in place and provided with annual health checks. Patients with a diagnosis of dementia were supported to make decisions about their care.

However, we did identify there were potential risks to patients safety in all population groups. This was in regard the safe administration and management of medicines at the practice, the management of the control of infection and a risk assessment process when recruiting staff.

Summary of findings

What people who use the service say

We spoke with two representatives of the patient participation group (PPG) and five patients during the day. We received information from the six comment cards left at the practice premises.

We reviewed the most recent information available for the practice on patient satisfaction. This included information from the national patient survey 2013/2014 and the Patient Participation Group survey. We also looked at information on NHS Choices website and information from Healthwatch.

Patients were positive about the care and treatment they had. Patients said they felt the practice offered an excellent level of care and treatment. Patients told us staff were caring, helpful and treated them with dignity and respect. Patients' told us the practice and staff were much appreciated.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and they had felt involved in planning and making decisions about their care and treatment.

Information from the NHS GP patient survey showed patients were positive about the emotional support provided by the practice and rated it above the national average in this area. One person informed us how much they had appreciated the support as a family when serious ill health occurred with one member or the family. We were informed they had found the named GP fully understood the persons' needs and provided both emotional and practical medical support.

Areas for improvement

Action the service MUST take to improve

- Improve the management of medicines and emergency equipment to ensure the safety of patients and staff.
- Improve quality assurance processes to ensure emergency equipment is fit for purpose, infection control systems are in place and actions taken to minimise the risks to patients and staff.
- Ensure their recruitment processes include a risk assessment to identify where a Disclosure and Barring Service check is required.

Action the service SHOULD take to improve

In addition the provider should:

- The practice should monitor and implement actions to ensure the practice environment is accessible to patients or staff with limited mobility or wheel chair users.

Bruton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Bruton Surgery

The Bruton Surgery is situated in Bruton, Somerset. The practice had approximately 6,071 registered patients including those patients from the outlying villages within a five mile radius of the practice. The practice provides care and support to patients in four care homes and three boarding schools in the area and based on information from NHS England and the practice shows us that the practice has a larger that average population of children and young people aged 0 to 19 years.

The practice is located in premises with patient areas on the ground floor; one small office area is on the first floor. The practice has six consulting rooms and one nurses or minor operations room. There are also two rooms used for either phlebotomy and for chronic disease management. The practice is on a primary medical service contract with Somerset Clinical Commissioning Group.

The Bruton Surgery is only provided from one location:

The Bruton Surgery

Patwell Lane

Bruton

Somerset

BA10 0EG

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

Over 35% of patients registered with the practice were working aged from 15 to 44 years; just fewer than 28% were aged from 45 to 64 years old. Just below 11% were over 65 years old. Around 6% of the practices patients were 75-84 years old and just over 2% of patients were over 85%. Just below 19% patients were less than 14 years of age. Information from Public Health England showed (2012/2013) that 60% of the patients had long standing health conditions, which was above the national average of 53%. The percentage of patients who had caring responsibilities was just over 19% which is above the national average of 18.5%. Less than 1% of the working population were unemployed which is below the national average of 6.3%.

The practice consisted of four partners who employed one salaried GP. Of these five GPs there were three male and two female GPs. Three practice nurses and one health care assistant provided health screening and treatment five days a week. There were three phlebotomists (Phlebotomists are specialist clinical support workers who take blood samples from patients for testing) and 14 support staff employed. The practice was open between the hours of 8:30am and 6.00pm Monday to Friday. Evening surgeries were available between 6pm to 7.30pm on Mondays and every alternate Tuesdays. The practice referred patients to another provider, NHS 111 service for an out-of-hours service to deal with any urgent patient needs when the practice was closed.

Detailed findings

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.

Please note that when referring to information throughout this report, for example any reference to the Quality Outcomes Framework (QOF), 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. We spoke with a manager of the community nursing team associated with the practice. We received feedback from the pharmacist involved in working with the practice. We also had comments from a representative from one of the boarding schools whose pupils were patients who received treatment from the practice.

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 two of the GPs, a practice nurse, the practice manager and the reception and administration staff on duty. We spoke with two representatives of the PPG (patient participation group) and five patients in person during the day. We received information from the six comment cards left at the practice premises.

We observed how the practice was run, the interactions between patients and staff and the overall patient experience.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, they reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, it was identified there had been a breakdown in communication in informing the patient of the reason laboratory tests and test results had been given back to patient before a clinician had reviewed the results. Incorrect information had then been given. The event was investigated and training provided to staff. We saw minutes of meetings where incidents and events were discussed and staff were alerted to situations or risks in order to prevent them reoccurring.

We spoke with GPs and reviewed information about clinical and non clinical incidents that had occurred at the practice. We were given information that eight incidents had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included a failure to provide a prescription to treat an infection and record keeping, where the wrong information was scanned into a different patient's record. There had also been a failure in management of the vaccines 'cold chain' (vaccines should be stored and transferred at the appropriate temperature).

Where events should to be raised externally, with other providers or other relevant bodies, this had happened and appropriate steps taken. For example, highlighting poor discharge information given to the practice when a patient was discharged from hospital. Where the safety of vaccines was identified because the fridge temperature had risen too high, NHS England were informed and actions taken, including informing patients concerned.

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 a summary of the significant events that had occurred during the last year and discussed the outcomes and learning from some of the incidents with the GPs. Discussions of significant events was a standing item on the partners' regular meetings agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example implementing new protocols for the management of vaccines.

National patient safety alerts were raised and discussed at the partners' meetings and disseminated to other staff if relevant to their role. Information was stored on the practice intranet so that it was readily available. Partners and other staff were alerted by email if they did not attend partners' meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We were informed that all new staff received training in safeguarding in their induction programme. We looked at training records which showed that most staff had received relevant role specific training on safeguarding. We were informed that new staff were booked on training relevant to their role. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults or children and had undertaken child protection training at level three. All other staff had training relevant to their roles, GPs and nursing staff level two and administration and receptions staff to level one in adult and children's safeguarding. All staff we spoke with were aware who the safeguarding lead was and who to speak with in the practice if they had a safeguarding concern. Staff had access to information on the intranet, the practice managers office or reception.

There was a system to highlight vulnerable patients on the practice's electronic records. We were told there was one patient on the 'at risk' list at the practice. There was a weekly review of patients on the child and adult safeguarding 'watch list'.

Patients we met were aware they could request a chaperone to support them if needed for consultations, examinations or treatment. Nursing staff told us they had

accompanied GPs or other staff when required. There was a chaperone policy in place. We were told formal training for staff was planned for additional staff to provide this other than the nursing staff.

Medicines management

We looked at the medicines used at the practice. We checked medicines stored in the treatment rooms and medicine refrigerators. We found there was a small amount of medicines stored at the practice. However, they were kept in an unlocked cupboard in the treatment room. When we spoke with staff they were unable to provide information about monitoring stock levels or any audits carried out for medicines held at the practice. We were told the room where medicines were stored was rarely unattended by staff and was not routinely locked. We did observe staff leave this room at times such as collecting patients from the waiting room.

We were told about the processes that were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. No controlled medicines were kept on the premises.

There was a repeat prescribing policy which gave details of the practices processes including the requirement for regular reviews of patients on long term treatment. Patients could make their requests by varied means and were provided with information on how to do this in the patient leaflets and on the practice website.

The practice worked in conjunction with the local pharmacy. We spoke with the pharmacist about working with the practice to improve the current system they could, check patients' notes with their permission, to ensure appropriate prescribing occurs. We were told the practice was looking at electronic prescribing in the future. One GP had received specific training to provide misuse of drugs prescriptions (FP10MDA).

We looked at the systems for the storage and safety of vaccines at the practice. We saw from information provided by the practice during September 2014 that a concern had arose about the temperature storage of vaccines at the practice. The temperature had risen above the manufacturers guidelines for an unknown period of time. We saw that actions were taken to prevent a reoccurrence, NHS England were informed and patients contacted. Regular checks were made and records of the fridge temperatures and new protocols had now been put in place.

The nursing staff administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw that practice nurses responsible for the administration of vaccines had training updates in the administering of travel vaccines and an anaphylaxis refresher within the past 13 months. We were told the practice administered a higher than average number of travel vaccines to support the patients residing at the local boarding schools.

Cleanliness and infection control

We observed the premises to be clean. The practice employed a cleaner directly who came into the practice during opening hours. There was no formal recorded cleaning audit carried out. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead practice nurse for infection control. We were told all staff received induction training about infection control specific to their role. There was no evidence of recent training for the lead practice nurse or any of the clinical staff. The nurse on duty informed us that they had not attending infection control training for at least five years. We saw evidence that an infection control audit had been carried out in February 2013, with no significant issues identified. A subsequent audit on 5 November 2014 identified a number of issues and concerns including, poor hand wash facilities, unsuitable flooring and a lack of foot operated waste bins in some non clinical rooms. At the time of the inspection an action plan or risk assessments had not been put in place to ensure improvements were made.

We saw that the building and some of the areas where clinical activities took place were difficult to manage in accordance to best practice with infection control. Space was limited in staff and public toilets for appropriate recommended hand wash basins and elbow operated taps. There was a small sink in one consulting room that did not have sufficient space for practitioners to wash up to below their elbows as advised by Department of Health (DOH) guidance.

Are services safe?

Hand washing sinks with liquid hand soap and paper towel dispensers were available in the other treatment rooms and where staff and patients needed to wash their hands. Notices about hand hygiene techniques were displayed in staff and patient toilets. There was a separate hand sink in consulting and treatment rooms.

We looked at the facilities in the main clinical room where minor surgery took place. We saw that there was limited space for storage of equipment, work surfaces were not clear of items and easy to clean. The conditions of the cupboards were poor and coverings and edgings compromised the control of infection as they were permeable and not easy to clean. Flooring was a mixture of linoleum and concrete and did not meet current Department of Health (DOH) guidance (Infection control in the built environment, 2013). The flooring in clinical areas should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant.

The condition of the clinical treatment room had been picked up in an audit assessment in 2008 when plans had been raised for a new building for the practice in the town. These proposals had fallen through. The practice manager, GPs and nursing staff told us they were aware of the necessity to improve this main clinical treatment room at the practice and therefore had raised plans for refurbishment of this area. They could not provide a specific date of when these improvements would be put in place.

The practice had an infection control policy and supporting procedures were available for staff reference. For example, hand decontamination policy and how to respond to a needle-stick injury. We observed that personal protective equipment including disposable gloves and aprons and were available for staff to use.

There were appropriate systems in place for the disposal of used needles (sharps) and clinical waste. In the clinical and consulting rooms we viewed there were foot pedal operated bins and designated clinical waste bins. We did not review all of the clinical rooms as they were in use during the inspection. The practice had a contractual agreement with a clinical waste disposal company who managed the collection and removal of clinical waste.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. Safety checks were carried out on vaccine fridges on an annual basis.

Staffing and recruitment

We were told about the recent changes in the staff team recently following the departure of one of the partners and changes to the administration team.

We looked at records for two of the most recently employed staff at the practice. We found the practice asked applicants to submit a curriculum vitae however; there was no written evidence that the detail about their full work history had been checked such as where gaps in employment were identified. We saw photographic proof of identity was taken and where required for their role a criminal record check through the Disclosure and Barring Service (DBS) had also been carried out. The practices' policy was to carry out DBS checks on all clinical staff, but not necessarily the non-clinical staff. There was no risk assessment process in place to evidence the decision making process for this.

Records we looked at contained evidence of reference checks and qualifications. For the GP partner there was detail about their registrations with the appropriate professional bodies such as the GMC and the performers list.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included a recorded interview and decision making process for all new applicants. New members of staff were given a formal induction appropriate to role which included general employment at the practice, health and safety and job specific.

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. We were told that the practice only used locums that they had verified and were known to them, for example one partner was on maternity leave and her clinical sessions were being shared by a current and an ex-partner acting as locums. We were told the practice rarely uses a locum agency and only in an absolute emergency.

Inadequate

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks relating to facilities such as heating and lighting in regard to the environment, some aspects of medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety lead.

There were environmental and safety risks that were identified, assessed, rated and actions recorded to reduce and manage the risk such as fire safety. We saw that there were some aspects of the environment, such as disability access that were not routinely reviewed or risk assessed. For example, limited doorway access to some of the rooms used for consultation and treatment. The corridor running through the centre of the building was narrow and did not allow passing space for pedestrians when being used by a wheel chair user. We heard how staff accommodated patients with restricted mobility, by using consulting rooms at the front of the building. We saw from the Patient Participation Group (PPG) results of a survey 2013 they had identified that the practice was not able to provide additional services because of access and availability of space at the practice. Inadequate pedestrian access was also highlighted. Plans were put forward to provide a larger space for phlebotomy to take place in one of the larger treatment or consulting room.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Unplanned admissions and re-admissions to hospital for older people were regularly reviewed with input from the district nursing to prevent reoccurrence. Patients from this group and those with long term conditions had a care plan in place which identified potential risk and reduced them. Staff were alerted to patients at risk on the electronic patient records so that they could respond appropriately and alert GPs or practice nurses as soon as possible to concerns.

Children at risk were identified and concerns were discussed with other service providers or practitioners such as health visitors.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Nursing staff and those involved in direct patient care had received training in early 2014. Emergency equipment was available including oxygen, emergency medicines and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The external defibrillator was kept in reception area which was attended by staff at all times the practice was open. Emergency equipment, medicines and oxygen were held in the main treatment room. Staff knew the location of this equipment and the emergency medicines.

We looked at the system and records of safety checks for the emergency equipment. We were told these were carried out daily and monthly depending on the equipment concerned. Records of these checks were noted electronically. We looked at how the emergency medicines, equipment and oxygen were stored. We found emergency medicines were kept in a box in the bottom drawer of a trolley storage system. We found the hinge of the box lid was broken and therefore was not fully secure. We looked at dates and condition of the medicines held and found all were in date and suitably packaged. We looked at the other emergency equipment held with the emergency medicines box and found there were face masks/ resuscitation masks and several copies of guidance held in the same drawer. These items were dusty and therefore it was uncertain they had been checked appropriately. The guidance for staff for emergency resuscitation was from various dates including 2005, which could be misleading as we could see current guidance was on display in a prominent place in the clinical room for all to see.

We looked at the storage and safety of the oxygen cylinder. We checked with the practice nurse if there were any other sources of oxygen at the practice, which we were informed there were none. We found the medium sized cylinder unsecured. The cylinder was not in a trolley or chained to the wall to prevent it falling. There was no signage outside the door to alert the emergency services and public that oxygen was stored in the room.

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 computer system failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the water and telephone companies.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff they practised regular fire drills, and we were informed that all staff had been provided with training and had been trained as fire marshals.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told that one GP took the lead on reviewing, summarising and ensuring information was disseminated to staff. We heard about practice meetings where new guidance was discussed and actions developed to implement.

The practice had a programme of regular assessments and reviews of treatment for patients with long term conditions such as asthma, heart disease and diabetes. Patients with learning difficulties, experiencing poor mental health or complex needs were identified and were monitored with a plan developed for on-going care. From information provided by the practice there were nine patients with learning difficulties on their patient list.

There were GPs at the practice that had particular interests in specialist clinical areas. For example, orthopaedics or dermatology. There were designated leads for safeguarding adults and children. Another GP led and had been trained in caring for patients being treated for the misuse of drugs.

We saw no evidence of discrimination when making care and treatment decisions. Discussions with GPs and information available showed that the culture in the practice was that patients were referred on their assessed need and that age, sex and race was not taken into account in this decision-making.

New patients were required to complete a health questionnaire and offered a health check when they registered. Patients with on-going treatment plans were placed on the schedules of regular monitoring. Patients we spoke with told us about their experiences at the practice including when initial registering with the practice. They told us they were given information about the practice. Patients were offered a health check and any immediate health needs would be responded to.

Management, monitoring and improving outcomes for people

The practice showed us and told us about clinical audits that had been undertaken in the last year. One example of a recent audit was in regard to using new guidance for routine testing used to screen patients potentially at risk from diabetes. The audit looked at a sample group of patients where routine blood tests had been carried out including and looked at specific haemoglobin levels (haemoglobin is the molecule in red blood cells that carries oxygen). They reviewed information, implemented checks and concluded the current usual screening checks still met the needs of the patients and no change to practice was required. The practice provided us with information that it was also engaged in monitoring male patients for prostate cancer. This was using the Department of Health guidance and setting up a programme of offering screening to all symptomatic male patients. Each patient would be looked at individually and discussed by the GPs before the next step taken.

We looked at information about the practice from the Quality Outcomes Framework (QOF). QOF is a national performance measurement tool or indicators to check patients received the treatment and support they required. For example, patients with respiratory disease, diabetes, chronic heart disease, or poor mental health. We saw from historic information provided by the practice that showed the practice was high performers (99.6%) during 2012/2013 in meeting the QOF indicators. GPs and nursing staff were involved in the regular monitoring of patients health care needs. Patients we spoke with confirmed that regular checks were offered and provided to them. Patients told us they had not experienced any concerns and had been referred in a timely way to other health care providers such as for hospital treatment. Patients told us they had valued the treatment they had received at the practice. One GP who had a special interest in dermatology carried out minor operations at the practice which enabled patients to have treatment and investigations commenced locally without attending a hospital or clinic further away.

The practice had a register of patients requiring support for end of life care and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Each patient had a plan of care in place.

There was an informal system of peer review for GPs within the practice where GPs discussed decision making and plans of treatment. These processes included group and individual discussions with GP leads.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staff included medical, nursing, managerial and administrative staff. We saw an overview of staff training and found that records did not reflect what we were told. Staff they told us they were up to date and had regular training and had access to online training. Staff had access to training from the Local Medical Committee (LMC) such as safeguarding and practice management. We found there was an undue length of time since some staff had received infection control training. There was no recorded information as to formal training received by staff. One member of nursing staff stated it was more than four years previously that they had attended training for infection control. We were told that all staff were to be provided with training in dementia awareness as it was the aim of the practice to be dementia friendly in 2015. Training was provided through internal, online and external training providers.

GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or were working through the process of revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). We were informed that the practice GPs were members of the Somerset GP Education Trust where they accessed training. In house education occurred three to four times each year. We heard they used the weekly partners meetings to update on changes in guidance and best practice.

All staff undertook annual appraisals which identified staff learning needs. Staff confirmed that the practice provided training and took an interest in developing their skills and extending their roles. New non-clinical staff had access to an "Introduction to General Practice" course from the LMC.

Practice nurses and the health care assistant and phlebotomists had defined duties they were expected to carry out and were able to demonstrate they were trained to fulfil these duties. For example training had been undertaken for, the administration of vaccines, cervical cytology and the on-going monitoring of patients long term needs conditions.

We were told there was a model of sharing information and although patients had a named GP there was GP 'buddy' system for covering duties that assured continuity of care for patients. It also allowed for pathology and other test results to be reviewed without any delay. The practice always had a duty GP available to respond to queries and emergency needs of patients whilst the practice was open. The practice provided routine GP surgeries at three local boarding schools. GPs provided medical support to four care homes in the area. We spoke with one representative of a boarding school to whom the practice provided this service to. They told us the school was visited regularly. When we spoke with patients attending the practice we noted from their conversations that the GPs commitment to providing care at the boarding schools had no impact on the delivery of care to other patients at the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and provide treatment and support to people with long term and complex health needs. We were told about the work the practice did with other health providers and practitioners. Health visitors met for regular clinics at the practice. The district nursing team were provided with access in order to update and manage their patient records.

The practice staff and a manager of the community district nursing team told us about their joint working and the multidisciplinary meetings held to discuss and provide support to patients. This included supporting patients placed on the Gold Standards Framework (GSF) pathway for end of life care.

The practice used an out of hour's service. Information about patients who had attended or required out of hours support was received and responded to by the practice the next working day.

Information Sharing

The practice told us they had migrated to a new system for patient records and the management of the service during the last six months. This provided greater flexibility for sharing information with other providers using a similar system. This included automatic updates made to patients' Summary Care Record (SCR). SCR's provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. The new data system has been set up to alert GPs to clinical tasks required to be carried out and a same day messaging service to reception staff meant the system highlighted activities that were required to be completed.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The GPs we spoke with were aware of the Mental Capacity Act (2005) and the Children's and Families Act 2014 and their duties to fulfil it. The practice had guidelines and information available to staff and information about patients seen to be at risk was shared and also discussed at the weekly practice meetings.

Patients with learning disabilities and those with a diagnosis of dementia were supported to make decisions about their care. This was through the use of care plans which they were involved in the development during consultations with their GPs. GPs were aware of processes and systems for best interest decision making and involved others in any assessment of capacity to make decision. This often involved other health care practitioners, the patients' carers and social workers involved in patient's support. Information was recorded in patients' care plans, these were reviewed regularly.

Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). When we spoke with a school nurse and a pupil from one of the local boarding schools it was clear that young patients were given information and support to make decisions about their care and treatment. What was also evident was information was shared when young patients were at deemed at risk or required support from their parents or guardians.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, written consent was obtained and scanned into electronic patients records. A patient's verbal consent for examination and tests was documented in the electronic patient notes. Patients we spoke with confirmed that GPs and nursing staff asked for consent before examining them or providing treatment.

Health Promotion & Prevention

The practice provided new patients with an information pack when they first registered with the practice.

The practice offered all new patients registering with the practice a health check with the health care assistant or practice nurse. If health concerns were detected a GP was informed and these were followed up. Patients on repeat medications were automatically requested to make an appointment with a GP for regular health and medication checks.

The practice also offered 'well women' and 'well men' health checks. Health advice and support was given when patients attended appointments for areas such as smoking cessation.

The practice kept a register of all patients with learning disabilities and with mental health needs and offered them an annual physical health check. There was a method of identifying at risk groups such as those receiving end of life care and those over 75 years of age. Staff undertook testing for memory and dementia screening with older patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw from the most recent information available to us from NHS England for 2013, the practice had identified 150 children below the age of five years old who were on a programme of childhood immunisations. Staff sign-posted young people towards sexual health clinics and offered confidential testing packs for sexually transmitted infections. The practice told us they had recognised they needed to develop further the support they provided directly to young adults in providing sexual health guidance at the practice. There was multidisciplinary working between GPs, practice nurses, the district nursing team and visiting midwives and health visitors.

The practice displayed patient health promotion information in the waiting room and patients had access to health information through the practice website. Patients were signposted to external support groups and provided with information about the support the practice could assist them with. For example, the most recent practice newsletter provided by the Patient Participation Group (PPG) gave guidance on the practices behalf about NHS adult screening services that were available.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from the national patient survey 2013/ 2014, the Patient Participation Group survey 2014 and comment cards we left in the practice reception. We also looked at information on NHS Choices website and information from Healthwatch. We spent time talking with patients at the practice.

Patients who completed the CQC comment cards provided us with feedback on the practice. All patients were positive about the care and treatment they had. Patients said they felt the practice offered an excellent level of care and treatment. Patients told us staff were caring, helpful and treated them with dignity and respect. Patients' told us the practice and staff were much appreciated.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We observed that some patient conversations at the reception desk could be heard in the waiting room even though staff tried to speak quietly and discreetly.

Patients were called to their appointments via the television screen in the waiting room. We saw practice nurses and GPs physically go into the waiting room to call patients or escort them back to the waiting room particularly the elderly or frail. We saw they communicated well.

Care planning and involvement in decisions about care and treatment

Patients told us had felt involved in planning and making decisions about their care and treatment. GPs and nursing staff had a good understanding of assessing patients' capacity to be involved in decisions about their care and treatment and they involved others such as carers and advocates when required.

Staff told us that translation services were available for patients who did not have English as a first language. A notice was on display at the reception desk informing patients this service was available. References were not made on the public website for translation services on offer when visiting the practice. There was a drop down menu for providing the website information in another language.

Patient/carer support to cope emotionally with care and treatment

Information from the NHS GP patient survey from 2013 showed patients had experienced their GP was good or very good at treating them with care and concern. Patients rated it at 93% which was above the national average of 85% in this area. One person informed us how much they had appreciated the support as a family when serious ill health occurred with one member or the family. We were informed they had found the named GP fully understood the persons' needs and provided both emotional and practical medical support.

Notices in the waiting room sign-posted patients to support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were told the practice had a carer's champion, an identified member of staff to assist and sign-post carers to additional help and support. We saw from the latest newsletter issued by the Patient Participation Group (PPG) carers' were provided with information about a local befriending service and access to carers groups.

We were told about how the practice hosted a 'talk and support' twice a week for carers at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to people's needs and had systems and flexibility to act when patients needs changed.

We were told by the practice there had been a small turnover of staff during recent months but this had now settled. Patients told us they were able to see the GP of their choice or their named GP which enabled continuity of care. GPs provided routine home visits to patients who had difficulty attending the practice. There was always a duty GP available when the practice was open to respond to an emergency need or if patients had or queries or concerns that arose. Regular weekly visits were made to the three local boarding schools to provide patient care to the young people living there. Patients' from the boarding schools could still attend the practice at other times between these routine surgeries at the schools.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The outcomes had resulted in changes to the methods of repeat prescription requests by installing a drop box for repeat prescriptions in August 2013. The lack of identity badges for staff had been addressed in January 2014.

The practice had implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. It was able to offer extended hours after the practices usual opening hours regularly each Monday and alternate Tuesday evenings for those who were unable to attend during the usual working day.

The practice had access to online and telephone translation services. From information available to us there were a low number of patients who attended the practice who did not have English as their first language.

The practice was aware of the premises and services had limited facilities to meet the needs of people with disabilities. Patient consultation and treatment rooms were all ground floor level. However, the central corridor running from the front of the building was narrow and did not allow passing space for wheel chair users or those with poor mobility. The patients' waiting room was screened off from the corridor to consulting and treatment room areas. The limited space in the patient waiting room made access difficult to navigate past patients waiting at the reception desk. There was only one toilet off the waiting room that was designated specifically for disabled patients. Some adaptations had been put in place to provide extra space and safety aids such as hand rails. However, patients had to navigate through two doors to access the toilet and there was restricted flexibility to how these were used particularly by independent wheel chair users.

The main treatment room had restricted space and access to areas such as the treatment couch was limited because of the need to store equipment in the same area. One treatment consulting room at the rear of the building was not suitable for wheelchair access as the doorway was narrow.

The last audit of the premises in regard to disability access had been carried out in 2008 in regard to a proposed development of a new practice location and building. Some of the issues with access to the building were highlighted in this audit and remain unchanged. For example, the condition of the treatment room, access in the corridor and no recovery or isolation area. Concerns about privacy at reception and no separate telephone area were also identified. In addition the audit identified issues with the facilities in regard to access for disabled employees. There was no alternative access such as a lift to the upstairs administration room which was also used as a staff room and meeting room.

Access to the service

Appointments were available from 8:30.am to 7:30 pm on Mondays and alternate Tuesdays. Normal working hours were from 8 am to 6.30pm on the other days.

Information was available to patients about appointments on the practice website and in patient leaflets. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were early evening appointments available so that patients could attend appointments out of normal working hours.

Good

Are services responsive to people's needs?

(for example, to feedback?)

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients in leaflets, on display in the practice and on the practices website.

Patients' comments showed us that at times the appointment system was not always satisfactory for them. Two of the patients we spoke with on the day of the inspection and one comment card we received showed that patients were not fully satisfied with the appointments system. This was not the opinion of all the patients we spoke with or had comments from. Patients told us they had experienced they could see a GP on the same day in if they had an urgent need for treatment and they could see another GP if there was a wait to see the GP of their choice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system and was included in information leaflets provided to them and on display in prominent areas of the premises. The practice included detail of the complaints policy and procedure on their website. Patients we spoke with told us they were aware of the complaints procedure but had no reason to raise a complaint.

We looked at the information about 12 concerns identified and managed as complaints that were received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way.

The practice had an annual review process to look at complaints or significant events for trends or themes. We looked at the summary report for complaints during the last 12 months we saw lessons learnt from individual complaints had been acted upon. For example, the administration of referral processes were reviewed and updated and staff were given appropriate guidance. Another complaint concerned the information about fees for non NHS services. Reception staff were reminded to direct patients to information on the practice website and in the practice and to obtain patients written agreement before treatment was carried out. We saw that complainants were always offered an opportunity to discuss their concerns with practice staff.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

When we spoke with staff it was evident the practice had high value placed on continuity of care for all their patients. They had identified in their Statement of Purpose that they wanted to provide the best possible quality service for their patients within a confidential and safe environment by working together. This was reflected in the information received from the community district nursing team. The practice had also identified they wanted to ensure patients were involved in the decision making about their treatment. This was reflected in the feedback from patients and their supporters when we spoke with them.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We saw policies and procedures had been developed to meet the needs of the practice and the specific services it provided. We looked in detail at the practices policies and procedures relation to clinical care such as infection control. We saw and heard about the clinical protocols in place at the practice. There were policies and procedures for safe working practices such as fire safety. There were polices relating to the recruitment, employment and training of staff. All policies and procedures we looked at had been reviewed annually. We saw that some policies and procedures were not fully followed by staff such as infection control and the storage of medicines and emergency equipment.

The GP partners at the practice held weekly meetings where a range of topics were discussed and planned for including complaints and significant events.

The practice had a system and lines of accountability for the supervision and appraisal of staff. We saw records relating to the employed staff that supported these events occurred.

The practice had completed clinical audits, the most recent was relating to the screening of patients at risk of or a potential risk of diabetes. For example, they looked at using other information from blood tests carried out as the main indicator of the patients' risk of diabetes and another tool to monitor patients to prevent them potentially missing the correct diagnosis. We saw from information provided they had concluded they could not use this information from these blood tests in isolation and continued to carry out screening in the usual way.

We were provided with information about an audit carried out in regard to the uptake and use of the chaperone service. They had looked at the information in regard to female examinations by male GPs. They identified and put in practice indicators to be included on the patient records about the use of chaperone and to clearly record that a chaperone was offered at the time of the examination.

The practice had arrangements for identifying, recording and managing risks. We saw risk assessments relating to infection control and fire safety. Where risks were identified, not all had action plans had been produced. Where an action plan had been produced they were not always implemented. For example, the audits for infection control.

Leadership, openness and transparency

There was a leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and two partners were the leads for safeguarding, one for adults another for children. The practice manager was supported by a GP partner in responding to and acting upon any complaints made to the practice. All of the staff we spoke with understood 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.

We heard that team meetings were held regularly. Meetings were relevant to the roles staff were employed for. Information was cascaded to other staff. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings or with the practice manager.

The practice manager was responsible for the implementation of human resource policies and procedures. We reviewed a number of policies, for example, the recruitment policy. There was information to show that staff were provided with copies of policies and procedures relating to their employment in a staff handbook. For example, their responsibilities for maintaining confidentiality and complaints handling. Key information regarding working at the practice was available on line for staff and from the practice manager's office. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Requires improvement

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

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. We also saw they responded to comments about the practice that were left on NHS Choices. We looked at the results of the annual patient survey that was carried out in early 2014. The practice had 74 respondents and from this exercise identified areas of concerns expressed as well as areas that patients felt positive about the practice. They had found that there was a mixed response to patient's satisfaction with access to appointments. To address some of the issues, how the information was given on the practice's website was reviewed and changed to make clear the system of appointments.

The practice had an active patient participation group (PPG) which is small but mostly represented the patient population the practice serves. The practice and the PPG were aware they had a higher than expected younger patients' age group because of the boarding schools in the local area it supports. The practice in partnership with the PPG had been looking at methods of actively seeking patients from this patient group to participate and was initiating assistance from the schools to do this The PPG had carried out annual surveys and had met at least three times each year. The practice manager and the lead GP had participated and provided a link to the PPG at these meetings. The minutes from these meetings, results and actions agreed from these surveys were available on the practice website for patients to read.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us they had received annual appraisals and this was reflected in the records we reviewed. Staff told us they had access to training and development including meeting with their peers from other practices at training provided by the local medical committee.

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

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 The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

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 The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of these Regulations; and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.