

Ward Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ward Practice, also known as Honiton Surgery, on Wednesday 16 August 2017. Overall the practice is rated as good. The well led domain requires improvement.

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

- There was an open and transparent approach to safety and a system in place for reporting and learning from significant events, although records kept did not clearly demonstrate this.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective clinical care and treatment.
- The GPs and nursing team used clinical audit to monitor and improve services and clinical care.
- The GPs provided medical input and were able to admit patients to the local community hospital

medical ward. This enabled older or patients at the end of life to be looked after closer to home, with the continuity of care from the community rehabilitation team.

- The practice worked jointly with healthcare professionals from the local acute trust and benefitted from educational sessions provided by this team. This enabled patients to be treated within their local community.
- The practice had a system for identifying patient at risk of falling. These patients were then referred to the local falls team nurse who visited and assessed the patient at their home. The GPs then worked with a local rehabilitation team to address the risk factors.
- Patients told us they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. Patients were complimentary about the staff group and said the care they received was efficient and thorough.
- Prescription management and medicines at the practice were well managed.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

Summary of findings

- Feedback from patients reported that access to a named GP and continuity of care was not always available in a timely way, although urgent appointments were available the same day. The provider was aware of this feedback and had taken steps to communicate the reasons for this and implemented actions to mitigate risk whilst further staff were being recruited.
- Extended appointments were available in the morning on Mondays, Wednesdays and Thursdays and late evening appointments were offered on Tuesdays and Wednesdays.
- The practice had recently extended the building to provide additional clinical and office space. The facilities were clean, tidy and well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the GP partners.
- The practice proactively sought feedback from staff and patients, which it acted on. Examples of changes included additional appointment times, changes to patient car parking, introduction of water dispenser and staff badges.
- Despite many changes over the last year, staff said it was a good place to work and morale was high.
- There was a formal structure of meetings to aid communication with external health care providers and staff at the practice.

- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are to ensure:

- Effective systems and processes are established to ensure good governance in accordance with the fundamental standards of care, particularly in regard of; record keeping, risk management and staff development.

The areas where the provider should make improvement are:

- Improve the systems to identify carers to ensure they receive all the information and support required.
- Review records relating to significant event processes to ensure they reflect the actions taken and lessons learnt.
- Review appraisal records to ensure they show that the findings are agreed by the staff being appraised and the appraiser.

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?

The practice is rated as good for providing safe services.

Good



- There was an effective system for reporting significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and an apology. They were told about any actions to improve processes to prevent the same thing happening again. However, governance arrangements did not always ensure records reflected the action that had been taken or that lessons were shared.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety relating to medicines management and infection control.
- Governance arrangements did not always ensure recruitment records were fully maintained to demonstrate that all pre-employment checks had been performed.
- An environmental risk assessment had not been completed at the time of inspection.
- Staff demonstrated that they understood their responsibilities on safeguarding children and vulnerable adults relevant to their role. However, training records did not reflect the training staff told us they had received.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Previous data from the practices that had merged showed patient outcomes for the Quality and Outcomes framework were at or above average compared to the national average. Unverified data for 2016/16 also showed the practice was likely to be performing well.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment. Systems were not monitored to demonstrate that staff had received mandatory training. A new eLearning programme was being introduced to assist with this.
- There was evidence personal development plans for all staff.

Summary of findings

- Not all staff had received an appraisal in the previous year but this was being addressed.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Feedback from patients reported that access to a named GP and continuity of care was not always available in a timely way, although urgent appointments were usually available the same day. The provider was aware of this feedback and had taken steps to communicate the reasons for this and implement actions to mitigate risk whilst further staff were being recruited.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led.

Requires improvement



Summary of findings

- The GPs had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. There were clear lines of accountability in place. Staff were clear about the vision and their responsibilities in relation to it.
- Staff felt supported by the GPs and their line managers. The practice had policies and procedures to govern activity and held regular governance meetings.
- The governance framework and records kept at the practice did not always support, monitor and identify risk. For example, recruitment procedures had not been followed, systems had not identified that administration staff had not received an appraisal in the last year and training records had not been kept up to date to show gaps in refresher training. In addition appropriate environmental risk assessments had not been carried out or action points recorded in a timely way.
- Staff had received inductions and attended staff meetings.
- The provider was aware of the requirements of the duty of candour. We saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken. Although records did not always demonstrate the actions taken and learning that staff said had taken place.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels although training records were not always kept up to date.

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

The practice is rated as good for the care of older patients.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice had a system for identifying patient at risk of falling. These patients were then referred to the local falls team nurse who visited and assessed the patient at their home. The GPs then worked with a local rehabilitation team to address the risk factors.
- The GPs provided medical input and were able to admit patients to the local community hospital's medical ward. This enabled older or patients at the end of life to be looked after closer to home, with the continuity of care from the community rehabilitation team.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- The GPs provided a personal medical service to 181 patients across seven care homes. Each care home had been allocated with a named GP for continuity of care.

People with long term conditions

The practice is rated as good for the care of patients with long-term conditions.

Good



- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- The practice held vascular clinics which encompassed primary and secondary prevention of cardiovascular disease (hypertension, hyperlipidaemia), asthma and chronic obstructive pulmonary disease (COPD). COPD is a chronic lung disease.
- Each chronic disease clinic was supported by a lead GP to provide advice if required.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice held educational meetings for GPs and nurses. For example, woman's health update (including contraception), asthma and COPD update. The clinical team learned from case based discussions at the weekly clinical meetings (discussing complex or challenging cases advice/support), clinical audit and review, and from the twice yearly whole team significant event analysis meetings.
- Clinical staff worked with specialist teams from the local acute NHS in the management of long term conditions including diabetes. Twice yearly virtual clinics were held which provided practice staff with guidance on more complex diabetic care and provided opportunities for education.
- Patients could access additional support and advice through the practice website linking to local and national self-help forums and support groups. There were also links to other NHS websites such as patient code.uk and health information on the national website NHS choices.
- The practice considered health promotion as an important aspect of care and actively signposted patients to weight management, alcohol reduction, smoking cessation support and exercise programs.
- Practice staff and members of the patient participation group (PPG) had held educational events with different themes. For examples men's health, women's health, and mental health so patients had a better knowledge of health conditions and services available for help.
- Quarterly palliative care meetings were held with hospice care team and community nurses to discuss patients on the

Summary of findings

palliative care register and highlight any patients where increasing intervention was necessary. In addition, a white board was maintained to highlight patients receiving end of life care. This was updated by GPs and hospice nurses.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems 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.
- Post-natal checks and eight week baby checks were offered in line with immunisation programmes.
- Patients told us, on the day of inspection, that 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.

- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young patients and for acute pregnancy complications.
- The practice promoted the use of a leaflet and provided an app called HANDi which provided advice, support and guidance for common childhood illnesses. For example, what to do if a child has a temperature and guidance of when to contact a GP, call NHS 111 or 999.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age patients (including those recently retired and students).

- The needs of these populations 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 appointments were available in the morning on Mondays, Wednesdays and Thursdays and late evening appointments on Tuesdays and Wednesdays for working patients.

Good



Summary of findings

- Telephone appointments, triage appointments and face to face appointments were available.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

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 those with a learning disability. One of the GPs led the care for patients with learning disabilities.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients who needed them.
- The practice regularly worked with other health care professionals, for example, the learning disabilities nurse in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young patients and adults whose circumstances may make them vulnerable. They 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.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of patients experiencing poor mental health (including patients living with dementia).

- The practice carried out advance care planning for patients living with dementia. Practice staff were offered dementia awareness training at clinical meetings.
- 87% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 85%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.

Good



Summary of findings

- The practice was situated next to a mental health service. GPs regularly worked with these multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had updated their website to ensure information was available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations. GPs also referred patients to local voluntary services and supported patients to self-refer to services including Recovery and Integration Service (RISE) which was a Devon-wide adult substance misuse service, working with people with alcohol and drug problems.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

There were no national GP patient survey results available for this practice.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of care received. Comments included compliments about the staff, premises and treatment provided. However, four of these comment cards referred to frustrations and complaints relating to timeliness of getting a non-urgent appointment with a GP.

We spoke with nine patients during the inspection and one member of the patient participation group. Eight of these patients said they were dissatisfied with the appointment system, stating they often had to wait for up to three weeks to get an appointment with a GP. However five of these eight patients told us they had made the appointment on the same day or the day before. Two patients had been given appointments when receptionists followed a 'red flag' process. One patient had been given an appointment because of their age and another two patients had been triaged by the GP and

were asked to attend the practice in person. All patients told us that once they had obtained an appointment, the care and treatment was excellent, efficient, respectful and of good quality. The provider was aware of this feedback and had taken steps to communicate the reasons for this and implemented actions to mitigate risk whilst further staff were being recruited. Patients were also complimentary about the staff and thought staff were approachable, committed and caring.

We looked at the friends and family test results for May, June and July 2017. Of the 28 results 19 patients said they would recommend the practice. Positive comments included feedback about the staff, efficiency of the service, care and treatment and clean and tidy environment. Nine patients said they would be unlikely or extremely unlikely to recommend the practice. Comments included negative feedback about the time taken to see the GP, problems getting a timely appointment and one comment related to the attitude of staff.

Ward Practice

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 adviser and a practice manager specialist adviser.

Background to Ward Practice

Ward Practice, also known as Honiton Surgery, is a GP practice which provides its services under a Personal Medical Service (PMS) contract for approximately 16,800 patients.

The practice is situated in the Devon town of Honiton and is made up of two separate practices who merged in the last year.

The practice is open Monday to Friday between 8.30am and 6pm. Outside of these hours patients are directed to the local NHS 111 out of hours provider as part of a local agreement. Out of hours information is displayed outside of the practice, within the newsletter and within the patient information leaflet. Extended hours are offered but not freely advertised on the website or in the patient newsletter. Patients were advised to speak with a receptionist about these. We were told these were between 7.30am and 8am on Monday, Wednesday and Thursdays and from 6.30pm until 8pm and sometimes 8.30pm on Tuesdays and Wednesdays.

Routine appointments could be made between three and six months in advance. Urgent appointments were available on the same day for patients using the telephone

triage system where they would speak with a GP first. There is a system to ensure patients falling within certain criteria would automatically see a GP. For example, children under the age of five years old.

The practice population is in the eighth decile for deprivation. In a score of one to ten, the lower the decile the more deprived an area is. There is a practice age distribution of male and female patients equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 81 years and females living to an average of 85 years.

There is a team of 12 GPs (eight female and four male). Of the 12 GPs, 11 are GP partners, holding financial and managerial responsibility of the practice. Together they provide a whole time equivalent (WTE) of eight GPs. The team of GPs are supported by nine registered nurses, one bank registered nurse and ten health care assistants. The clinical team are supported by a practice manager and a team of over 30 administration and reception staff and a team of four cleaning staff.

The practice is a teaching practice for medical students and is also a Royal College of GPs (RCGPs) research practice.

The GPs provide medical support to five care homes and two homes for patients with learning disabilities.

The practice is registered to provide regulated activities which include:

Treatment of disease, disorder or injury, surgical procedures, maternity and midwifery services and Diagnostic and screening procedures and operate from the main site of:

Marlpits Road,
Honiton,

Detailed findings

EX14 2NY.

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. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 August 2017.

During our visit we:

- Spoke with a range of staff including six GPs, the practice manager, the practice manager's assistant, four administration staff, three practice nurses and one health care assistant. We received 22 staff questionnaires completed by staff.
- Spoke with nine patients who use the service and one member of the patient participation group.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members

- Reviewed 13 comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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?
- Is it well-led?

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

- Older people.
- People with long-term conditions.
- Families, children and young people.
- Working age people (including those recently retired and students).
- People whose circumstances may make them vulnerable.
- People experiencing poor mental health (including people living with dementia).

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

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us there were documents at the practice to initially record any incidents. Staff explained that there was a no blame culture and supportive environment should errors or near misses occurred. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Staff explained that immediate action was always taken to ensure patient safety. The GPs would be informed and external organisations contacted as necessary. For example, public health England or NHS England. Staff added that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again. Staff explained communication about significant events was good at the practice and added that the whole staff group were included in the significant event meetings. There were opportunities to discuss events at weekly staff meetings, twice monthly nurse meetings and then reviewed at the six monthly significant event meetings.
- Significant event meeting minutes were provided to demonstrate these events were discussed. However, governance arrangements for records of the investigation and outcome did not always demonstrate, in detail, the actions taken as described by staff. For example, a missed diagnosis had been identified by a GP and managed promptly. Minutes of meetings showed that this event had been discussed by the GPs but records did not demonstrate the action that had been taken or the learning as described by staff.
- We saw evidence that lessons were shared appropriately. For example, practice nurses had identified an issue regarding the care and blood test results of a diabetic patient in the community. Staff

explained the action taken included communicating with the community nursing teams to ensure blood tests were appropriately managed, understood and actioned appropriately by all clinicians.

- The GPs and nurses explained that systems were in place to monitor trends in significant events and fully evaluated to ensure action had been taken. However, records did not always clearly reflect this.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety. However, not all of these were fully implemented, monitored or recorded.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding. The lead safeguarding GP attended safeguarding meetings when possible and provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and where to find guidance and contact details of local safeguarding teams.
- Staff told us they had received training on safeguarding children and vulnerable adults relevant to their role. The practice manager told us GPs were trained to child protection or child safeguarding level three. However, governance arrangements and records had not ensured that this training had been completed for four of the 12 GPs. These certificates were produced following the inspection.
- The safeguarding training record for nurses showed 13 of the 16 nursing staff had received level two child protection training. However, governance arrangements had not identified one member of staff had not been included on the training record, despite working at the practice for a period of 10 months. There were no safeguarding training certificates available for this member of staff. Records showed that all remaining staff had received training to level one.
- A notice in the waiting room and clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS)

Are services safe?

check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. A new infection prevention and control (IPC) lead nurse had been appointed in June 2017. They had reviewed these cleaning schedules and were in the process of introducing monitoring systems.
- There was an IPC protocol. The IPC lead had accessed the health protection agency website to obtain information and policies relating to current evidence based practice. All but two of the nursing team had received up to date IPC training. E-Learning was in the process of being introduced to the wider staff group with a new e-Learning programme. This included IPC training.
- The lead IPC nurse had identified that annual IPC audits had not been performed in the last year so this was being undertaken on the day of inspection. We saw evidence that action plans included the improvements identified. For example, carpets and fabric chairs in consulting rooms. The practice manager was aware of these issues and said they had been identified for replacement as part of future refurbishment plans.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice were managed by the nursing team and minimised risks to patient safety (including obtaining, recording, handling, storing, security and disposal).

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.
- Detailed records and failsafe processes had been introduced by the nursing team and maintained for the storage and stock control of medicines kept at the practice. Storage facilities were clean, tidy and managed efficiently.

The GPs monitored the prescribing patterns at the practice. There were processes for handling repeat prescriptions

which included the review of high risk medicines. Repeat prescriptions were signed before being sent to the pharmacist and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

Following an audit and discussion at clinical meetings, the GPs had made a decision to use a 'grab bag' of medicines should the need arise to take medicines on a home visit. This was securely stored in a central area and was checked by the nursing team to ensure they were always in date and ready to use.

Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed six personnel files for staff whom had been recruited since October 2015 and found governance arrangements had not identified that all appropriate recruitment checks had been undertaken or recorded in the examples we looked at. For example:

- An appropriate check through the disclosure and barring service (DBS) was not present for one of the six files. This was for a health care assistant. The member of staff told us they thought this had been performed as copies of proof of identification had been requested. The practice manager gave us assurance that this would be repeated if the DBS could not be located.
- There was no evidence that checks had been performed for one of the nurses to demonstrate registration with the appropriate professional body. An updated Nursing and midwifery and General Medical Council list was provided after the inspection.
- Four of the files did not evidence that contain proof of identity including a recent photograph had been obtained prior to employment or retained for audit purposes. Although we noted this information would have been collected and checked to issue the staff NHS security cards.
- Two folders for a registered nurse and a healthcare assistant did not show details of indemnity insurance. This evidence was provided following the inspection.

Are services safe?

All six files contained two written references, a signed contract, job description and application form or details of full employment history. All six folders contained evidence that a confidentiality policy had been read and understood. An updated checklist to demonstrate GPs were registered with the General Medical Council (GMC) was sent following the inspection.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety, however, these had not been consistently monitored or responded to in a timely way.

- There was a health and safety policy was available but we noted that a new maintenance package had not yet been fully implemented yet.
- The practice had an up to date fire risk assessment which had been carried out in September 2016 by a specialist contractor. The report of this stated that actions should have been addressed by September 2017. Staff were able to explain the action taken but there were no records to demonstrate that this action had been taken. The practice carried out regular fire drills. The last drill had taken place in July 2017. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. Fire alarms and emergency lighting had last been serviced in March 2017.
- All electrical and clinical equipment had been checked and calibrated in October 2016 to ensure it was safe to use and was in good working order.
- There had been extensive building work carried out at the practice over the last two years to introduce more clinical and administrative space. A full environmental health assessment had not been performed at the time of inspection. The practice manager was unaware this was required but provided it within three working days of the inspection.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice had employed an external

contractor who had performed a risk assessment in the last month regarding the risk of legionella. There had been risks identified including not having records of water temperature checks. We saw an email agreement to show the company would be visiting the site to carry out water checks, although this had not been recorded on the risk assessment..

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The whole team were skilled in a variety of procedures and a 'buddy' system was in place when staff were absent.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Records showed that all GPs and all but one of the nursing team had received basic life support training in the last year. Staff we spoke with told us they had received resuscitation training in the last year. However, records did not reflect this. We saw a health and safety training record had not been updated to reflect that staff had received refresher training in basic life support. For example, the record showed that 28 of the 66 staff listed had not received a resuscitation training update in the last year.
- Emergency medicines and equipment were available in the treatment room and all staff knew of their location.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Detailed records demonstrated systems were managed by the nursing staff to ensure all routine and emergency medicines were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. These guidelines were incorporated on templates used at the practice.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The GPs held six weekly audit meetings where the QOF scores were reviewed and provided opportunities to identify where further action was required.

Because the practice had merged with another practice in the last two years there was no published and verified data available for the merged practice. However, both practices had achieved higher than the clinical commissioning group (CCG) average QOF scores for 2015/16. For example, 99% compared to the CCG average of 96% and national average of 95%. The practice had results of the 2016/17 data which showed the practice had achieved 434.79 of the 435 points available. The data also showed that the practice had achieved 86 of the 86 diabetic points and 26 of the 26 mental health points.

There was no data available for overall exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients were unable to attend a review meeting or certain medicines could not be prescribed because of side effects).

There was evidence of quality improvement including clinical audit:

- We looked at five clinical audits commenced in the last two years, three of these were completed audits where the improvements made were implemented and

monitored. The remaining two included a study to look for a case cluster of patients with Motor Neurone Disease. This audit was performed with a neighbouring practice. Results were sent to Public Health England to investigate and no further investigation was required.

- Findings were used by the practice to improve services. For example, an audit of patients who were not responding to blood thinning medicines was undertaken. These patients were at risk of developing complications. The GP conducting the audit, did a search on the computer system which highlighted 412 patients on a specific blood thinning medicine (Warfarin). The audit highlighted 47 patients with a blood test outside of normal range and resulted in 28 patients being reviewed where changes to their medicines were made. This change resulted in health benefits for the patient and a benefit to the health economy because these patients would not require as many tests.

Information about patients' outcomes was used to make improvements. For example, referral reviews took place to ensure referrals were done in a timely way and were appropriate. These included all referrals made by locum staff.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff we spoke with said they had received suitable support in their new roles and had access to appropriate training.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nursing staff had access to refresher training. For example, cervical smears, child immunisations, travel vaccinations and long term condition updates. Staff were able access to on line resources and discussed any changes at practice meetings.
- All staff spoken with said they felt supported in the workplace. Staff said they had access to training and could speak with their line manager, the practice

Are services effective?

(for example, treatment is effective)

manager or GPs informally at any time. Of the 26 staff surveys, 23 said they had opportunities to attend training. We saw records kept by the nursing team to show they had received an appraisal in the last year. However, we saw that governance arrangements for appraisal records had not identified that administration staff had not received an appraisal in 2016. For example, the record showed that seven of 37 staff had not received an appraisal in the preceding year. We noted these had either been recently carried out earlier this year or booked for later this year. We looked at five appraisal records and noted that three had not been signed by both the appraiser and appraisee.

- Staff explained that their learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. The nursing team had developed revalidation folders for all members of the nursing team, including healthcare assistants. These were used to store appraisals, training certificates and other documents. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses.
- Staff told us they received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. However, the training records for this e-learning were incomplete and had not been updated.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. The practice shared, with patient consent, relevant information with out of hours providers and emergency services using a computer system. This ensured the patient received prompt treatment and continuity of care.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

We spoke with the manager of a local care home where GPs visited. They told us the communication between the practice and care home was effective and the care and treatment the GPs provided was prompt, caring and respectful. The manager said feedback from residents was positive and staff from the practice were approachable, friendly and helpful.

We spoke with a health care professional who was visiting the practice on the day of inspection. They told us the practice staff were responsive and keen to develop professional working relationships with the new community nursing team.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Staff at the practice worked effectively with other healthcare providers to provide coordinated and efficient care. For example:

- The respiratory nurses and diabetic nurses work with healthcare professionals from the local acute hospital to deliver educational meetings and discussion of patient care.
- The GPs were working towards social prescribing with a neighbouring GP practice.
- Practice staff work with the patient participation group to provide educational sessions for patients. These have also included working with a charity to provide a 'mole awareness' morning.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- The clinical team understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. One

Are services effective?

(for example, treatment is effective)

of the GPs had booked a lunchtime session to provide Mental Capacity Act awareness training for all staff until the new e-learning programme had been fully introduced.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- The process for seeking consent was obtained and recorded using templates embedded onto the patient records. We saw examples where this consent had been recorded. We saw written consent forms used for minor surgery. Staff explained that these were then scanned into the patient record.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- There was a room at the practice where patients could check their own weight and blood pressure.
- The TV display in the waiting areas and practice website were used for health promotion.
- Patients were supported to self-refer to the local drug and alcohol advice service and children's single point of access.
- Patients could be referred to a 12 week exercise programme. 41 patients had benefitted from this service.
- GPs referred patients to the 'One small Step' programme. This was funded and run by Devon County Council and aimed to help the increasing number of adults at risk of developing a long-term health conditions by taking small steps, including reducing alcohol intake, stopping smoking and increasing activity to help toward a healthier lifestyle.

The practice's uptake for the cervical screening programme was 83%, which was comparable with the CCG average of 82% and the national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice supported those with a learning disability and ensured the learning disabilities nurse and a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. For example, 63% of patients between the ages of 60 and 69 had attended for bowel screening in the last 30 months compared to the national average of 58%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Results of uptake rates for the vaccines were variable. The nursing team were aware of this and thought a computer recording system (coding) at the time of merger was responsible for the variable results as low rating results did not tally with comparable ratings given at the same time. This was being investigated by the nursing team. For example 96% of children aged one had received their full course of recommended vaccines which was above the target of 90%. 91% of children aged two had received a measles, mumps and rubella vaccine. However, only 85% of children aged two were shown as having received a haemophilus influenza type b and meningitis C booster vaccine. Uptake results for five year old vaccines were above national targets. For example, between 94% and 97% of five year olds had received a measles, mumps and rubella booster, compared to a national average of between 88% and 94%.

Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

There were no results from the national GP survey. This was because of the two practices merging.

We received 13 comment cards which were all positive about the standard of care received. Comments included compliments about the staff and care and treatment provided. There were four comments about the respect shown by staff.

We spoke with nine patients during the inspection and one member of the patient participation group. All patients told us that once they had obtained an appointment, the care and treatment was excellent, efficient, respectful and of good quality. Patients were also complimentary about the staff and thought staff were approachable, committed and caring. Patients said they never felt rushed during the appointment.

We looked at the friends and family test results for May, June and July 2017. Of the 28 results 19 patients said they would recommend the practice. Positive comments included feedback about the staff, efficiency of the service, care and treatment.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also 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 available to them.

Patients gave examples of where the GPs and nursing staff had empowered them to be involved in their care and lifestyle. One patient told us their diabetes would not have been as well controlled without the input and advice from the nurses. One patient explained how the GP had drawn diagrams of their condition and printed information leaflets from the internet to help explain their condition. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. We spoke with two parents who said the GPs and nursing staff had interacted positively and age appropriately with their children.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 73 patients as carers (0.4% of the practice list). The practice used new patient questionnaires to identify new carers and a dedicated notice board in the waiting room provided information to direct carers to the various avenues of support available to them.

Are services caring?

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Monday, Wednesday and Thursday mornings from 7.30am until 8.30am and on Tuesday and Wednesday evenings until 8pm. Extended appointments were mentioned on the practice website. Patients were advised to speak with a receptionist regarding these.
- There were longer appointments available for patients who needed them. Nursing staff said they could extend these appointments should they be required.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice.
- Named GPs attended care homes in the area to provide continuity of care for patients and effective communication with care home staff.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning. This included GPs completing treatment escalation plans with patients and their families.
- The practice had a 'red flag' system in place to fast track patients to see a GP rather than using the telephone triage system. This included same day appointments for children and those patients with medical problems that require same day consultation.
- Children's waiting areas were provided within the practice.
- TV screens in the waiting areas provided patients with health information and changes about the practice.
- The practice sent text message reminders of appointments and test results and were able to cancel appointments using this facility.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- The practice had recently been extended to include further consultation rooms and office space. This extension had provided more accessible facilities for patients.

- The accessible facilities included a hearing loop, and interpretation services.
- A quiet interview room was available for patients who wanted to talk to staff confidentially or for mothers who wanted to breastfeed in privacy.
- The practice had installed a lift to improve access to upper levels of the premises. There were automatic opening doors and accessible toilets within the practice.

Access to the service

The practice was open Monday to Friday between 8.30am and 6pm. Outside of these hours patients are directed to the local NHS 111 out of hours provider as part of an agreement. This information was displayed outside of the practice, within the newsletter and within the patient information leaflet. Extended hours were offered but not freely advertised on the website or in the patient newsletter. Patients were advised to speak with a receptionist about these. We were told these were between 7.30am and 8am on Mondays, Wednesdays and Thursdays and from 6.30pm until 8pm and sometimes 8.30pm on Tuesdays and Wednesdays.

There were no results from the national GP patient survey about access to appointments because of the recent merger.

Patient feedback about getting a non-urgent appointment was mainly negative. All but one patient said they had experienced difficulty getting an appointment in the last year. Four of the nine patients had made their appointment on the same morning. One patient had spoken with the triage GP an hour before they were seen and within two hours of ringing the practice. One patient, with a complex medical history, was automatically given an urgent same day appointment and two children had been given an appointment on the same morning. However, all patients said that when they got to see a GP, the care, treatment and service was very good and faultless.

Five of the 13 comment cards contained negative comments about getting an appointment or continuity of care. For example, patients commented on the initial appointment time not being acceptable, frustrations with the appointment system, not having enough staff and significant waiting times. However, these four cards also contained very positive comments about the care and treatment received.

Are services responsive to people's needs?

(for example, to feedback?)

The practice staff were aware that there was dissatisfaction about difficulty getting an appointment and had received many grumbles and complaints about this. The merger had occurred at a time when GPs were retiring and recruitment of replacements had been difficult despite extensive advertising. The practice had taken steps to communicate and address this issue. For example:

- A newsletter sent in 2016 explained this issue and warned patients that there was going to be a delay in seeing a named GP until recruitment was completed.
- The practice discussed these issues with the patient participation group and at practice meetings to provide updates on the improvements made.
- A study of patients failing to attend (DNA) pre booked appointments earlier in 2017 was carried out and showed that over a two month period, 396 patients had not attended their appointments. This was communicated through the patient newsletter to highlight the challenges the practice faced when providing appointments.
- The practice staff had also provided a communication on their website and TV screens in the waiting areas. These explained the reasons for the difficulties of getting an appointment and advised of alternative forms of care and treatment including telephone consultations to discuss simple issues, speaking with a pharmacist and attending the minor injuries unit.
- A telephone triage system was used to screen which patients should be seen for urgent and same day appointments. Receptionists were educated and given guidance of 'red flags' which automatically meant patients would be seen on the same day. We saw evidence this system worked effectively for these patients.
- One of the GPs had written an article on 'the day in the life of a Honiton GP' for patients to see why clinics sometimes ran late with the unpredictable nature of illness.

- Locum staff were used to fill vacancies to help ensure appointments were available for patients.
- Ongoing recruitment was taking place. The latest practice newsletter stated that two new GPs (one whole time equivalent) were due to start work in September 2017.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Information on how to complain was provided in the new patient leaflet, complaints leaflet, on the website and on posters in the practice.
- There was a designated responsible person who handled all complaints in the practice.

We looked at six complaints received in the last 12 months and found had been satisfactorily handled, dealt with in a timely way with openness and transparency. Annual complaints review meetings were held to discuss trends and review complaint outcomes. Minutes showed that lessons were learned from individual concerns and complaints and also from analysis of trends. For example, a trend in negative feedback about appointments had resulted in communication to patients about the situation. Another complaint regarding a delayed diagnosis had led to reiteration of the process for GPs to follow and feedback given to the locum GP concerned.

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

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

- The practice had a mission statement which had been agreed at a staff away day and was displayed in the staff areas and staff knew and understood the values. New practice patients were issued with a Honiton practice charter which stated the undertakings of the staff.
- The practice GPs had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. GP partners discussed these at partners meetings.

Governance arrangements

The practice had a governance framework. However, aspects of this did not always support the delivery of the strategy or evidence the levels of services provided and were not always communicated to the GP partners in a timely way. The framework that worked well included structures and procedures and ensured that:

- Clear staffing structures and buddy systems were in place. Staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, safeguarding, prescribing, and infection control.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Lessons were learned following significant events and complaints.

However, there were not always failsafe or appropriate arrangements for identifying, recording and managing risk issues or implementing mitigating actions. For example:

- Recruitment records were incomplete and did not show that all pre-employment checks had been performed despite evidence indicating some of these checks had been completed.
- Training records were incomplete and did not demonstrate that staff had received appropriate training. For example, not including all members of staff on the training spreadsheet or identifying that some safeguarding training had not been completed. Where there were gaps we saw evidence to indicate training had occurred. The provider submitted this evidence shortly after the inspection.
- Appraisal records were not maintained to show that seven of the 37 administration staff had not received an appraisal in the last year.
- Environmental risk assessments had not been performed and risk assessment documents had not been kept up to date to demonstrate what action had been taken or agreed following a fire risk assessment and legionella risk assessment.
- Records of significant events did not always demonstrate the actions and learning described by staff.

Leadership and culture

On the day of inspection the GP partners in the practice demonstrated they had the experience, capacity and capability to run the practice to ensure high quality clinical care. However, they had not been aware of the gaps in governance procedures.

GPs told us they prioritised safe, high quality and compassionate care. Staff told us the GP partners and practice manager were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology.

Are services well-led?

Requires improvement 

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

- The practice kept written correspondence of these events but records did not always demonstrate verbal communication.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with community nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- There was a structure of clinical, practice, complaints, significant event and referral review meetings held. Minutes were kept of these meetings.
- Staff told us there was a mutual sense of respect, open culture and no negative hierarchy within the practice and said they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held every year. Staff said there were social events held throughout the year and added that despite all the changes and building work, staff morale had remained supportive and high.
- Staff said they felt respected, valued and supported, particularly by the GP partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from patients through the patient participation group (PPG), through surveys and complaints, through feedback from the NHS friends and family test and from complaints and compliments received. Changes as a result of patient feedback had included introduction of:

- Staff name badges
- Improving car parking facilities for patients
- More appointments in the morning and afternoon
- Child areas in the waiting areas and
- Water dispenser in the waiting area.

The practice also encouraged feedback from staff through discussion, informal feedback, staff meetings and appraisal. Changes made included moving a clinic, usually aimed at older patients to the ground floor and changing the prescription protocol so it was easier to understand and follow. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, The GPs were working towards social prescribing with a neighbouring GP practice and were part of a local federation to share ideas and resources.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>Systems, processes and records were not implemented or maintained to assess, monitor, manage and mitigate risks to the health and safety of patients who use services. For example:</p> <ul style="list-style-type: none">• Maintenance of and recording environmental risk assessments,• Following and recording recruitment processes and• Maintenance of staff training and appraisal records in a way to identify gaps in training. <p>This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>