St Leonard's Practice

Quality Report

St Leonard's Practice
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at St Leonard's Practice on 28 July 2015. The practice is rated as outstanding overall. It was outstanding for providing effective, responsive and well led services and good for providing safe and caring services. It was rated as outstanding for providing services for the population groups of older people and people with long term conditions, families, children and young people, vulnerable people and people experiencing poor mental health. It was rated as good for providing services to working age people.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).
- The practice had excellent facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place,

Summary of findings

was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We identified areas of outstanding practice;

Patients newly diagnosed with cancer were contacted by a nurse practitioner and offered an appointment. The nurses provided care for patients with cancer normally only available in hospital, such as the care of their intravenous lines. This avoided the need for frequent patient visits to hospital.

In June 2015 the practice had carried out a pilot primary care ophthalmology service to assess patient response to eye treatment at a GP practice. Findings had been positive. Of 27 eye patients, 23 had been successfully treated at the practice. The remaining four had been referred into secondary care. All 27 had been very happy with the service.

The practice was an internationally recognised lead for learning, research and improvement. GPs at the practice had a great deal of published work in medical journals and books to support this. There had been an extremely positive impact of this primary research and its publication to a global audience. Examples included the adoption of a system for the identification and management of type two diabetes, due to research and published work carried out by GPs at the practice.

Research at the practice had led to the development of the 'Devon Predictive Model' (DPM) which was adopted by the local clinical commissioning group (CCG) and also nationally to improve care for older people. The DPM works by close liaison with all healthcare providers to supply an analysis of all available data to provide a proactive and effective approach to patient care, especially for older people and at risk groups.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the clinical commissioning group (CCG). The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients were truly respected and valued as individuals and were empowered as partners in their care. Feedback from people who used the service and those close to them and stakeholders, showed that patients continually rated the practice higher than others for almost all aspects of care. Feedback from patients was consistently and strongly positive. We observed a strong, visible, patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient choices and preferences were valued and acted on. Staff showed determination and creativity to overcome obstacles to delivering care. Patients individual needs and preferences were reflected in the way care was delivered.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

Summary of findings

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. The practice had adopted a proactive approach by initiating positive service improvements for patients that were over and above contractual obligations. Continuity of care was seen as particularly important for patients attending the practice regularly, who were seen by the same named GP or nurse.

Suggestions for improvements were acted on and changes made to the way services were delivered in response to feedback from the patient participation group (PPG). The practice reviewed the needs of their local population and engaged with the NHS England Area Team and CCG to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had modern, well equipped facilities and was able to treat patients and meet their needs. People can access appointments and services in a way and at a time that suits them.

There was active review of complaints and how they were managed and responded to, and improvements were made as a result. People who use services were involved in the review. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for providing well-led services.

The leadership, governance and culture were used to drive and improve the delivery of high quality person centred care. The practice leaders had a strategy which was challenging and innovative with quality and safety as its top priority.

Governance and performance management arrangements are proactively reviewed and reflected best practice. There are high levels of staff satisfaction and high standards are promoted and owned by all practice staff and teams worked together across all roles.

There was strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction.

Innovative approaches were used to gather feedback from patients using new technology, and there was a very active patient participation group (PPG) which influenced practice development.

Summary of findings

The leadership drove for continuous improvement and staff are accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in their population and had a range of enhanced services, for example, in reducing unplanned admissions to hospital, dementia and end of life care. They were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice had a buddy system which ensured that if a named GP was absent, another GP had knowledge and experience of the absent GP's patients in order to meet their needs. Older patients we spoke with told us they valued this continuity.

The practice held regular meetings with local pharmacists, voluntary health care groups and community nursing teams to help ensure continuity of care for older people.

Research at the practice had led to the development of the 'Devon Predictive Model' (DPM) which was adopted by the local clinical commissioning group (CCG) and also nationally to improve care for older people. The DPM works by close liaison with all healthcare providers to supply an analysis of all available data to provide a proactive and effective approach to patient care, especially for older people and at risk groups.

The care for patients at the end of life was in line with the Gold Standard Framework. This meant practice staff worked, as part of a multidisciplinary team and with Out of Hours providers to ensure consistency of care and a shared understanding of the patient's wishes.

The practice was responsive to the needs of older people, GPs, nurses and health care assistants provided home visits and rapid access appointments for those with enhanced needs. We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over who were vulnerable had care plans in place. The practice told us this had reduced unplanned admissions.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions.

Summary of findings

The practice had instigated a call and recall integrated system to ensure patients with long term conditions received invitations to regular health checks and follow ups. Nurse-led care at the practice meant that these patients could make a single appointment for multiple treatments.

The practice provided effective cancer care and intra-venous central line care for patients, who may otherwise have to make frequent visits to hospital.

The practice identified patients who were at risk of developing diabetes with a proactive referral. Patients diagnosed with diabetes in this way had a significantly lower blood glucose average level, hence this has increased the number of patients for whom the onset of an associated long term condition has been either postposed or avoided. The opportunistic screening of patients for type two diabetes included the provision of information for patients on signs and symptoms to look out for. Data showed that by 2013, 88% of newly identified patients with type two diabetes had been diagnosed before symptoms were reported. The practice was part of the national diabetes audit benchmarking scheme and closely monitored their patients with long term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The impact of this was that patients most at risk received appropriate levels of care and support.

The practice provided 15 minute appointments for patients with long term conditions. Patients with more than one long term condition could make one extended annual review appointment in order to reduce the number of visits they made to the practice. The practice also promoted independence and encouraged self-care for these patients.

GP or nurse home visits and medicines reviews were arranged for patients who found it difficult to leave their homes.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and also cases of domestic violence. Records showed the lead GP liaised and sought advice from other health and social care professionals when necessary.

The practice provided baby immunisations, weighing and eight week checks. The midwife visited the practice once a week and there were immunisation clinics available. There were appointments for children available outside core school hours.

Summary of findings

Staff were knowledgeable about child protection and proactive in raising concerns with the safeguarding lead to follow up on any identified. A GP took the lead for safeguarding with the local authority and other professionals to safeguard children and families.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example the practice offered early morning appointments with the practice nurse and telephone consultations were available instead of patients attending the practice. The practice offered online prescription ordering with a 24 hour turn around and online appointment services.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. Annual health checks for people with a learning disability were carried out and health action plans updated. The practice had a register of vulnerable patients. The practice was part of a multi – disciplinary group made up of health and social care services who met monthly to monitor the health and well-being of this group of patients.

People experiencing poor mental health (including people with dementia)

Outstanding

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

The practice provided on site injections for patients experiencing poor mental health and had nurse-led protocols in place to support patients. The practice provided rooms and resources on site for local support agencies to provide cognitive behaviour therapy (CBT), counselling for patients experiencing poor mental health.

The practice employed a member of staff as a carers champion who provided advice to carers about the support available at the practice and from other relevant health professionals. This included carers of patients experiencing poor mental health including dementia.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and sign posted patients to the appropriate services. The practice participated in enhanced services for patients living with dementia

Summary of findings

and used screening tools to identify those patients at risk. With practice support, many of its staff and patients had successfully become dementia friends, with a raised awareness of the relevant issues.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing higher than local and national averages. There were 107 responses which represents 1.2% of the 8,797 practice population. There was a recurrent theme of patients saying that they were treated with support and care.

Results from the most recent GP national patient survey in 2015 stated that 94% of the patients who responded rated their overall experience of the practice as good. This was higher than the local Clinical Commissioning Group (CCG) average of 91%.

- 96% of respondents found staff at this surgery helpful compared with a CCG average of 91% and a national average of 87%.
- 94% of respondents said that the last GP they saw or spoke to was good at explaining tests and treatments compared with a CCG average of 90% and a national average of 86%.
- 95% of respondents said that the last GP they saw or spoke to was good at giving them enough time compared with a CCG average of 91% and a national average of 87%.

We also spoke with 14 patients and their views aligned with the comments in the Care Quality Commission comments cards we received. Patients gave us positive examples of treatment they received and the support offered by practice staff. All said they were treated with dignity, respect and kindness by staff. We also spoke with five members of the patient participation group (PPG) who provided us with evidence that the practice responded positively to feedback about the practice.

Outstanding practice

Patients newly diagnosed with cancer were contacted by a nurse practitioner and offered an appointment. The nurses provided care for patients with cancer normally only available in hospital, such as the care of their intravenous lines. This avoided the need for frequent patient visits to hospital.

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St Leonard's Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. It included a GP specialist adviser, a practice nurse specialist adviser and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to St Leonard's Practice

St Leonard's Practice was inspected on 28 July 2015. This was a comprehensive inspection.

The practice is situated in the city of Exeter. The practice provides a primary medical service to 8,797 patients. The practice is a training practice for doctors who are training to become GPs. The practice is also a research practice with close links to the Exeter Medical School.

There is a team of six GP partners (three female and three male). There were also three salaried GPs (two male and female). GP partners hold managerial and financial responsibility for running the business. The team were supported by a practice manager, operations manager, systems manager, finance manager and nurse manager. There was one nurse practitioner, four practice nurses, a nurse administrator and two phlebotomists. The clinical team were supported by additional reception, secretarial and administration staff.

The practice is open for appointments from Monday to Friday between the hours of 8.15am until 6pm. Appointments were available to be booked up to seven weeks in advance. Patients told us they felt the appointment system was good. Extended hours were offered by the GPs and nurses on a weekly rota basis. Appointments were available for early Monday mornings from 7.30am and later in the evening on Mondays until 8pm.

The practice had opted out of providing out-of-hours services to their own patients and referred them to an Out of Hour's service provider.

The practice had a personal medical services contract with the NHS.

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 and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission at that time.

How we carried out this inspection

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

- Is it safe?

Detailed findings

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

We also looked at how well services are provided for specific groups of people and what good care looks 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 with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 July 2015.

During our visit we spoke with a range of staff including six GPs, two practice nurses, the practice manager and members of reception and clerical staff. We spoke with 14 patients who used the service and five members of the Patient Participation Group. We reviewed 22 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts.

The number of incidents reported in the last 12 months was low but where they had occurred, investigations, outcomes and actions were clearly documented. The staff we spoke with were aware of their responsibilities to raise concerns and were able to describe the procedure for reporting incidents and near misses.

Staff were able to describe a recent incident involving a letter intended for a patient which was sent to another patient of similar name at the same address. The practice made corrections to their records immediately and apologised for the error. The practice put in place systems for double checking of patient records in order to avoid recurrence.

Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe. We reviewed minutes of meetings where incidents and complaints were discussed during the last 12 months and reviewed incident reports which had been collated for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the longer term.

Overview of safety systems and processes

Every month the practice discussed significant events at team meetings. Significant events and incidents were reported on a standardised form which included a description of the incident, what went well in handling the incident, what could have been done differently and what could be learned from the incident to prevent a recurrence. Staff including receptionists and administrators were aware of the process to follow and sent completed incident forms via email to the management team. There were written and computerised records of significant events that had occurred during the last year and we were able to review these. An example was seen whereby an administrative error had been made; the practice had complied with its duty of candour by admitting the error, being transparent and apologising to the patient concerned.

National patient safety alerts were disseminated by email and at the clinical meetings to staff. Staff we spoke with told us that they had received information about alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were safeguarding policies in place for both children and vulnerable adults which included contact details for local safeguarding and social care teams. Flowcharts detailing the procedure for escalating safeguarding concerns were posted in consultation rooms for quick reference to ensure staff reported any concerns promptly.

We saw training records dated July 2015 which showed that all staff had received relevant role specific training in child protection, this included all nurses being trained to level two. All administrative staff were trained to level one. Staff had also received training in the protection of vulnerable adults. The practice had appointed a specific GP to lead in safeguarding vulnerable adults and children. All GPs at the practice had been trained to level three in child protection and in safeguarding vulnerable adults. The practice maintained a child protection register which identified families with challenging issues which may lead to them becoming high risk in the future. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. We asked administrative staff about their most recent training, they were able to describe signs of abuse in older people, vulnerable adults and children. One staff member gave an example of how they had escalated a concern to the practice safeguarding lead. They were aware of their responsibilities and knew how to share information, record safeguarding concerns and knew how to contact the relevant agencies in working hours and outside of normal hours.

There was a red alert message system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The practice had a chaperone policy and signs were visible on the reception desk, notice board and in the consultation

rooms offering the chaperone service. Clinical staff provided the chaperone service. All clinical staff had received a Disclosure Barring Service (DBS) background check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures and described the

action to take in the event of a breach of these temperatures. The fridge temperature was checked and documented once a day and we saw appropriate temperature range had been maintained. The practice nurses were responsible for ensuring medicines were in stock and within their expiry dates. Vaccines were checked weekly for their expiry dates. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We reviewed cleaning schedules and records detailing the frequency and areas of cleaning undertaken. These schedules were detailed on an individual room basis and took into account the purpose of how each room was used. All of the patients we spoke with said they always found the practice to be clean and tidy and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits in the last year. For example, an infection control audit had been completed in May 2015. The audit had not identified any follow up actions. The audit was repeated every six months.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the practice had a clinical waste management protocol in place and waste was segregated, stored safely and disposed of by a professional waste company. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff informed us that all PPE and probes used in examinations were single use to minimise cross-infection risks.

The practice had a contract with an external agency for daily safe removal and disposal of sharps waste.

The practice had a risk assessment in place for Legionella (a germ found in the environment which can contaminate water systems in buildings). The premises was a new build which had been specifically designed to avoid such risks as legionella. The designers of this modern bespoke designed GP practice premises had considered the risk of legionella and how to avoid any such risk. For example, water temperatures were set at temperatures to prevent the existence of legionella.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly for patient use 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 was July 2015. A schedule of testing was in place. Calibration of medical equipment was undertaken by an external contractor annually.

Good

Are services safe?

Staffing and recruitment

Records showed that there was a low turnover of staff at the practice. We looked at three staff records, all of which contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring

Service (DBS). All of the records contained photographic identification. All staff who required a DBS check had received one. A written risk assessment was in place stating why a DBS check was not necessary for certain roles, for example, the role of the finance manager.

Original checks had been completed, which showed that the performers list had been checked when GPs and locums were recruited. Copies of medical defence insurance were seen in files, which were valid for the current year. The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number and skill-mix of staff, and that the numbers on duty met patient needs. Nurses had completed several advanced nursing diplomas. These included diabetes management, asthma and Chronic Obstructive Pulmonary Disease (COPD).

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

Monitoring safety and responding to risk

Twice a month health and safety matters were discussed at meetings or more frequently if required at the 'all staff' meetings. 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 risk assessments of staff and patient areas and fire risk assessments.

The practice had a health and safety manager and also had a health and safety policy reviewed in the last 12 months, in May 2015. Health and safety information was displayed for staff to see. We saw evidence of health and safety risk assessments where identified risks were logged in a risk assessment table.

Arrangements to deal with emergencies and major incidents

During the inspection we observed that the practice dealt with emergencies and major incidents very well. An emergency occurred on the day of the inspection. Practice staff successfully deployed a contingency plan. This included providing cover for staff appointments both face to face and on the telephone, together with providing support to other members of staff affected by the situation. The practice dealt with the emergency in a professional manner.

All staff had received training in basic life support in the last 12 months. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED – a device used to attempt to restart a person's heart in an emergency). Staff we spoke with all knew the location of this equipment and records confirmed that it was checked regularly. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. All equipment and adrenaline were in date and recorded on a chart. Equipment was available to help adults and children who were having difficulty breathing.

Every staff member with access to a computer screen could request immediate assistance. This function was used if a patient collapsed or who otherwise became acutely unwell. By requesting immediate assistance an alert goes to all logged-on users of the computer system.

Risks to safety from service developments, anticipated changes in demand and disruption were being assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations. A business continuity plan reviewed in July 2015 was in place. This covered the range of anticipated emergencies, assessed their potential impact and assigned responsibility to staff for alerting others and preventing escalation. This covered breakdown of systems including computers and adverse weather, including flooding.

Arrangements were in place to respond to the arrival of an infected or contaminated patient as well as a strategy to act in the event of a pandemic perhaps in collaboration

Good

Are services safe?

with other neighbouring practices and/or the Clinical Commissioning Group and Public Health England. Clear instructions for staff had been prepared and useful contact details listed.

The practice had a fire safety policy, a fire safety log book and designated members of staff had nominated duties.

Weekly fire alarm checks were undertaken and fire drills had been practiced regularly to ensure patients and staff could be evacuated in the event of a fire. An external agency provided annual fire protection equipment servicing and a fire risk assessment was in place.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided effective services to its patients.

The GPs and nursing staff were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patient needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist interest areas such as dermatology and diabetes. The practice nurses led clinics for specific conditions such as asthma, chronic obstructive pulmonary disorder and diabetes which allowed the GPs to focus on patients within their specialist areas. Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance. We saw practice performance data for patients was higher than the local clinical commissioning group (CCG) average. For example, the percentage of patients with diabetes on the register, who had received health checks in the last 12 months was 81.28% compared with a CCG average of 77.72%.

The practice used computerised tools for information regarding patients who had experienced an unplanned admission to hospital and this would be forwarded by the administration team to the patient's named GP.

The practice referred patients to secondary care and other community care services appropriately. Data showed that the practice was performing in line with CCG standards on referral rates for all conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. Patients we spoke with told us that they felt listened to in decision-making about their care.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. The practice managed the care of patients over the age of 75, patients with mental health conditions and patients receiving integrated and palliative care by allocating them a named GP.

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

The practice had a highly effective system for monitoring patients taking oral anticoagulant medicine The practice had achieved level four which meant that they had the latest modern desktop equipment and systems to carry out a blood test, including software to help guide staff what action to take. Every week patients taking warfarin had a blood test and if their results were outliers, they received a letter and an invitation to an appointment.

The percentage of patients with atrial fibrillation, measured within the last 12 months, who were currently treated with anticoagulation medicine therapy or an anti-platelet therapy was 100%. This was higher than the Clinical Commissioning Group average of 98%.

The practice showed us eight clinical and non-clinical audits that had been undertaken in the past year. The practice showed us examples where changes had been made following results of audits. We saw audit results regarding the management of medicines to and compliance with NICE guidance. It became apparent it was necessary to adjust some patient's dosage as a result of the audits. This had been completed.

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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 72% of patients with high blood pressure had

Outstanding ☆

Are services effective?

(for example, treatment is effective)

received a review, an improvement of 11% over the previous year. Other improvements included the fact that 94% of patients registered as smokers had received a review, which was an improvement on the 89% achieved the previous year.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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

Effective staffing

The practice had an experienced team of staff that included medical, nursing, managerial and administrative staff. We saw staff turnover had been very low. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The practice held long well established links with local medical schools and had provided training for student doctors and doctors continuing in their education and become GPs.

A supportive and positive staff culture was evident throughout our inspection. All clinical staff undertook annual appraisals which identified learning needs and the practice was proactive in providing training in the areas identified. Nursing staff at the practice had defined duties and were able to demonstrate they were trained to fulfil these duties. Those with extended roles for example, triage, had extended training in clinical assessment.

Working with colleagues and other services

The practice had effective working arrangements with a range of other services such as the local ambulance trust, out of hours services, health services and a range of local and voluntary groups. This included involvement in various multidisciplinary meetings including palliative care nurses, health visitors, social workers and district nurses to discuss vulnerable patients at risk, those with complex health needs, and how to reduce the number of patients needing hospital admission. The lead GP for safeguarding children attended multidisciplinary meetings with the school nurse, health visitors and midwives to discuss patients on the child protection register and other vulnerable children. This enabled the practice to have a multidisciplinary approach which ensured each patient received the appropriate level of care.

The practice worked with other service providers to meet patient needs and manage complex cases. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out-of-Hour's GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers, which were dealt with on the day they were received.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP Out-of-Hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Devon single point of access scheme. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Regular meetings were held throughout the practice. These included 'all-staff' meetings, clinical meetings and partner meetings, where discussions about risks and significant events were open and transparent. All staff felt able to contribute to discussions, share their views and suggest solutions.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and the Children's and Families Act 2014 and their duties in fulfilling it. Formal training in the Mental Capacity Act 2005 had been undertaken by GPs, nurses and senior administrative staff. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw evidence that a GP had been involved in a best interests meeting with a patient who lacked the capacity to understand or make choices about their care and treatment. GPs demonstrated an understanding of both Gillick competence and Fraser guidelines (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). Patients with a learning disability and those living with dementia were supported to make treatment decisions through the use of comprehensive care plans, which they were involved in agreeing.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the clinical commissioning group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. It was practice policy to offer all new patients registering with the practice a health check. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

The practice had achieved cervical screening rates of 88% which was higher than the national average of 81%.

We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. Research was also being carried out to compare different ways of preventing falls and associated injuries in older people.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 28 patients were registered as having a learning disability. Of these, 25 had received a health check in the last 12 months. The remaining three had been sent reminders. The practice used laminated pictures, diagrams and flip charts to explain care and treatment to patients. On the day of inspection we saw how these would be used, for example to support learning disabled patients undergoing a cervical smear.

The practice provided a smoking cessation clinic to assist 1,964 patients who were recorded as smokers. Of these, 1,197 had a written record of receiving smoking cessation advice about support and treatment. This had resulted in 18 of them quitting smoking. This was higher than the local CCG average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was 90-100% which was in line with, or above average for the CCG. The practice offered childhood immunisation schedules in alternative languages, such as Polish, to support patients who did not speak English as their native language. There was a clear policy for following up non-attenders by the named practice nurse.

The practice PPG had an organised walking group which promoted healthy exercise, socialisation and well-being, called the PPG Strollers Group.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from information from the national GP patient survey 2015. We spoke to 14 patients during our inspection, five PPG members and we received 22 Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed a high level of satisfaction of patients with their GP practice. The results of the practice patient satisfaction survey showed that of the 107 responses received, 96 % of patients said that staff at the practice were very helpful which was higher than the local clinical commissioning group average of 90%. We received 22 comment cards and all of these stated that the service was very good or outstanding.

Patients said the nurses and GPs were very caring and they had received an excellent service. One patient said they had received first class treatment at all times including when they were really unwell and needed advice and an emergency appointment. Patients said their GP always listened to what they had to say. Patients said their GP had given very good in-depth explanations when they needed further treatment. Others said the GP got the right information for them, listened to them and their questions had been answered.

We were provided with numerous examples of the high levels of compassion shown by staff at the practice towards their patients. One patient told us that they had come to the practice in a very hungry and exhausted condition. A practice nurse had recognised this and had made the patient a sandwich in the staff kitchen. Another patient told us that their relative living with dementia had been found in a confused state by a member of staff at the practice, who had ensured they got home safely.

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 room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow their confidentiality policy when discussing patient treatments so that confidential information was kept private. Patients said they felt the practice offered a good service and both clinical and administrative staff were helpful and caring. They said staff treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 88% of practice respondents said the GP involved them in care decisions. This matched the local (CCG) average of 88% and was higher than the national average of 84%. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

GPs and nurses were able to demonstrate an understanding of Gillick competence and Fraser guidelines used to help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of patients considered they were treated with care and concern during their consultation with the clinical team, higher than the 93% CCG average. The 14 patients we spoke with on the day of our inspection and 22 comment cards we received were also consistent with this survey information.

Good

Are services caring?

Notices in the patient waiting room, told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice held a carer's register. Appointments were available for carers to have a health check if required. The practice had a carers champion in the administration team who liaised closely with carers and provided information such as signposting carers to various support services available.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services are tailored to meet the needs of individuals and are delivered in a way to ensure flexibility, choice and continuity of care. We found the practice had made patient needs and preferences central to its systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had used innovative methods to achieve this. We saw evidence that the practice management team involved the patient participation group (PPG) in the development of their patient survey and action plans in response to the feedback received. For example, the practice had introduced mobile telephone texting reminders for patients who wished to receive these.

The practice services were flexible, provided choice and ensured continuity of care. The GPs had individual lists, to promote continuity, and stakeholders paid tribute to the focus on continuity of care within this practice.

The practice closely monitored patient demand for appointments and as a result was able to respond to this demand in a very short space of time. For example, the practice maintained graphs on the consultation rate of each of its GPs and could use this data to adjust staffing levels to meet patient demand, to amend GP rotas and to plan effectively to respond to future patient needs. The practice also carried out a weekly audit on how it had responded to patient demand for face to face or telephone appointments. It also monitored locum GP usage and any patient list size changes to ensure that each GP could respond to meet patient needs.

Patients newly diagnosed with cancer were contacted by a nurse practitioner, who, having received MacMillan Cancer Care training had developed a system to identify newly diagnosed patients to offer an appointment for a cancer care review. The nurses provided care for patients with cancer normally only available in hospital, such as the care of intravenous lines. This avoided the need for frequent patient visits to hospital. The practice has a green access code for all patients with cancer. The practice is involved in a research programme looking in to what symptoms and examinations are best for predicting lung and bowel cancer, to help with earlier diagnosis and treatment.

In response to an increasing level of patient demand, in June 2015 the practice had carried out a pilot primary care ophthalmology service to assess patient response to eye treatment at a GP practice. Findings had been positive. Of 27 eye patients, 23 had been successfully treated at practice. The remaining four had been referred into secondary care. All 27 had been very happy with the service.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. Temporary residents were welcomed.

The number of patients with a first language other than English was very low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The practice had level access and the patient areas were entirely based on the ground floor. The practice had wheelchair accessible toilet facilities.

The seats in the waiting area were of different heights and size. There was variation for diversity in physical health and all had arms on them to aid sitting or rising. A hearing aid induction audio loop was available for patients who were hard of hearing. There was an area for children to wait which had toys and books for them to use and read.

Access to the service

Patients told us they felt the appointment system was good. Extended hours were offered by the GPs and nurses on a weekly rota basis. Appointments were available for early Monday mornings from 7.30am and later in the evening on Mondays until 8pm.

The practice operated a telephone triage system for patients who needed urgent appointments. During morning surgery a duty GP could discuss health needs with

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

the patient and determine if an urgent appointment was required. The nurse practitioner also offered telephone triage and an acute same day service, the nurse is also trained to be an independent prescriber.

The practice varied the amount of appointments available depending on demand. Patients were able to book routine appointments up to seven weeks in advance with a preferred GP. Extra appointments were also released on a daily basis. All of the patients we spoke with on the day of inspection confirmed that they had been able to make an appointment with their preferred GP. This aligned with the comment cards with 12 individual positive references to the availability of appointments. The data we reviewed from the GP Patient Survey showed the practice had performed above the local and national averages in patient satisfaction with appointments. For example 92% of 107 patients who responded to the survey said they were able to get an appointment to see or speak to someone the last time they tried, higher than the clinical commissioning group and national averages.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The Practice Manager was the designated responsible person who managed all non-clinical complaints and the Clinical Lead managed all clinical complaints in the practice.

We saw that the complaints procedure was displayed on posters in the reception area and there was a complaints leaflet to help patients understand the complaints system. The practice had a complaints policy and maintained a complaints log. We looked at the complaints log for the last 12 months which recorded complaints received verbally, via email and in writing. We reviewed seven complaints received in the past year and found that these were satisfactorily handled.

At the time of our inspection the practice had one outstanding complaint being dealt with and there were no serious clinical complaints received in the last 12 months. The practice reviewed complaints to detect themes or trends. Lessons learned and actions taken in response to the complaints received were discussed and shared with staff.

The practice had received 11 compliments during the last 12 months. Feedback from these compliments had also been shared with staff.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a vision and strategy in place driven by quality and safety, which reflected compassion, dignity, respect and equality. All the staff we spoke with felt engaged with the vision and strategy through regular 'all staff' meetings, team building and a strong team culture at the practice.

There was strong democratic leadership at the practice which had a positive impact on the delivery of the service. For example, the practice was above average for 20 of the 27 outcomes measured by the GP Patient Survey of July 2015. This was significantly more than the national average.

The practice was above average for its Quality Outcomes Framework (QOF) performance. QOF success in 2014-12015 included attaining 427 clinical points out of a possible 435. This was an achievement of 98.2%. In total the practice had achieved 548 out of a possible 559 QOF points which was 98% and significantly higher than the Clinical Commissioning Group average.

From a patient point of view the practice was working well and in keeping with their mission statement which was to deliver quality personal healthcare to all its patients; working in a team in which each member was valued. GPs told us they consulted with all employed and community staff including health visitors, midwives, community nurses and the Patient Participation Group (PPG).

Governance arrangements

The practice had a clear structure of its governance arrangements. This structure was displayed in staff areas and showed the role of each member of staff at the practice, their title and reporting lines.

The practice had a number of policies and procedures in place to govern activity and these were readily available to staff on the desktop screen of any computer within the practice. The policies were reviewed annually and the practice discussed shared policies with other health professionals to ensure best practice. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GP leads for safeguarding. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. Staff we spoke with told us that QOF dashboard data was regularly discussed each month at clinical meetings and development plans were produced to improve targets. The practice also held an annual clinical meeting to discuss QOF and plan activities for the forthcoming year.

There were several examples to demonstrate the steady improvements in the delivery of more effective patient care and treatment. In 2013-14 the practice had scored 61.4% of QOF points in providing patients with high blood pressure with a review. The leadership of the practice had focused on this area. As a result the practice had improved its performance to 72% in 2014-15.

In 2013-14 the practice had offered smoking cessation support to 89% of its registered smokers. In 2014-15 the practice had improved this to 94%. This was higher than the CCG average.

The practice had an on-going programme of clinical audit cycles which it used to monitor quality and systems. Appropriate action had been taken as a result. The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

The practice had a programme for 'all staff' team meetings. These took place twice a month. All practice meetings were minuted, emailed to staff and stored on the computer hard drive. Staff told us that there was an open culture within the practice and they had the opportunity and felt encouraged to raise issues at team meetings. We reviewed a number of policies and procedures, for example recruitment, induction and staff appraisal which were in place to support staff. Staff we spoke with knew where to find these policies. The practice also had a whistleblowing policy which was available to all staff electronically or on paper which had been reviewed in the last 12 months. Staff were aware of the whistleblowing policy if they wished to raise any concerns.

Are services well-led?

Outstanding ☆

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

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

The practice acted on feedback in a positive way with a view to continuous improvement. We saw that each of the 14 comments posted online by patients on NHS Choices about the practice had been responded to. The practice scored 3.5 out of 5 stars, which was higher than the national average. Where there was also negative feedback, the practice had provided an explanation where appropriate and invited the informant to contact the practice manager to resolve any details.

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. Friends and family feedback over the last 12 months showed that 96% of patients would recommend the practice to their friends and family. This was higher than the CCG average.

The practice had a patient participation group (PPG). The PPG currently had 10 members. These members represented a diverse range of the six population groups. The group met up on a quarterly basis and described themselves as critical friends of the practice. Five members of the PPG attended the practice during our inspection and provided us with extremely positive feedback about the practice.

The practice also had a voluntary patient representation group (PRG) with over 200 active members, who met up online in a virtual forum on a regular basis. The PRG had raised money for equipment at the practice and other amenities such as a bench outside the entrance to the practice dedicated to a much loved deceased member of the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, staff had suggested replacing a rubber plant in the waiting room with an activity area for children. This had been implemented.

The practice had implemented ideas from the staff suggestions box. For example by displaying what services were available on-line in the waiting room, adopting a buddy system for the administration team so that when staff returned from absence they could get up to date with the latest developments easily via their buddy, and they could also provide staff cover for absences.

There was an ethos of continuous improvement at the practice. This was permeated by the provision of information boards around the practice which were regularly updated. They displayed such information as staff champions for different areas such as the website, QOF updates, immunisations, carer support, and patient medical reports.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice allocated protected time for discussions on referrals, results and prescribing and provided an opportunity for personal development and career progression.

We looked at three staff records including a GP, nurse and receptionist. We saw that regular appraisals took place for the clinical staff which identified areas for development with timescales for achieving these. Administrative staff had also had regular appraisals.

The practice closed for an hour between 1 – 2pm every Wednesday in order to deliver staff training. The time was used for group training sessions and sometimes an outside trainer attended. There was a strong focus on continuous learning and improvement at all levels of the organisation.

GPs at the practice had completed internationally recognised research. One of the GPs was the national lead for research in primary care. As a result his research had a wider impact than simply upon the practice alone. This GP leads a diabetes interest group. Published work from the practice which had been adopted as best practice both locally and internationally.

The practice was an internationally recognised lead for learning, research and improvement. GPs at the practice had a great deal of published work in medical journals and books to support this. There had been an extremely positive impact of this primary research and its publication to a global audience. Examples included the following:

- Education for Primary Care 2013 (4) “How does an increase in undergraduate teaching load affect GP teacher motivation?” This examined a hypothesis

Are services well-led?

Outstanding ☆

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

suggesting that as teaching load increases, motivation to teach may wane. Two factors may protect against this – adequate resourcing of teaching and support from colleagues and teaching institutions.

- British Medical Journal May 2014 examined the importance of improved GP training and more GPs.
- GPs at the practice were carrying out current research on the early diagnosis and prevention of type two diabetes, their work had been published in 2014.
- Journal of Public Health Advance Access February 2013 concluded that age had been undervalued as a risk factor for unplanned hospital admissions.
- British Journal of General Practice Oct 2010 had published a GPs work on "Confidentiality – a core feature of general practice".
- A GP had their work published in the American College of Physicians Journal 2012 – "The effect of adding systematic family history enquiry to cardiovascular disease risk assessment in primary care". This work concluded that gathering family history increases the proportion of patients identified as being high risk and requiring further targeted prevention.
- The British Journal of General Practice in June 2015 examined the "Provision of medical student teaching in UK general practice". This work concluded that the current levels of undergraduate teaching in general practice were too low to fulfil future workforce requirements. The report recommended that funding support for current teaching is low and central intervention may be required.
- A GP's article in The British Journal of General Practice in July 2015 examined the importance of continuity of care.

There were numerous research studies which the practice was currently supporting and working upon. These included;

- CLOUDS – an observational study to discover what health problems patients with screen detected type two diabetes developed and when these occurred.
- COBRA – a trial comparing two non-drug treatments for depression to see which worked best, behavioural activation or cognitive behaviour therapy.
- GARFIELD – observational study of adults with recently diagnosed atrial fibrillation and at least one other risk factor for stroke.
- TREAD – use of exercise to treat depression.

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