Fremington Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Fremington Medical Centre was inspected on Tuesday 14 October 2014. This was a comprehensive inspection.

Fremington Medical Centre provides primary medical services to people living in the very large quayside and inland village of Fremington and the area between the Bideford and Barnstaple bridges, North Devon.

At the time of this inspection approximately 6,400 patients were registered with the practice.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors and midwives.

We rated this practice as good overall with elements of outstanding practice and some aspects of the service that required improvement.

Our key findings were as follows:

- Patients told us they had found GPs and nurses to be very kind and compassionate, and reception staff were on the whole friendly. Patients thought the practice was well organised, and often found their own GP was good at communicating with them about their care needs and treatment options. Patients said they felt they had been listened to.
- The practice had done extensive work on their appointment system. They had introduced a full telephone triage system for GP urgent appointments. This had improved both continuity and access, because all patients with urgent needs were seen on the day by the duty GP, so other GPs were able to see their regular patients at booked appointments.
- Requests for home visits were triaged by GPs. One patient with a long term condition described how the system helped them. Their GP listened to their account of their varying condition, reviewed medication regularly, and the triage system meant they only needed to see the GP occasionally as telephone calls back meant they did not need to attend. They said they felt the GP cared about their well-being.

Summary of findings

- Patients felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.
- A trained nurse was the practice lead for infection prevention and control (IPC). She carried out an IPC audit, identified shortfalls and introduced improvements as a result.

We saw several areas of outstanding practice including:

- The practice had well above average clinical staff numbers for their population with 22 hours nursing provided per 1,000 population, with two nurse practitioners, four practice nurses and four health care assistants. This meant that nurses could offer patients appointments of 40 minutes to an hour to consider care and management of patients' chronic conditions. The nurse team leader made home visits where appropriate to discuss results of tests and review the care of frail and ill patients. Training for the health care assistants meant that one now was able to support the GP in minor operations, a second was trained for wound dressing and a third was a phlebotomist.

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.

Patients were confident in the care they received. The practice had systems to help ensure patient safety and staff had responded well to emergencies.

Staff received training and guidance to enable them to identify potential abuse of vulnerable adults or children. Significant events were discussed within the practice, with learning points recorded and action taken if necessary.

Infection control measures were in place and had been checked, improved and monitored to maintain clean and safe working arrangements.

Are services effective?

Good

The practice is rated as good for providing effective services.

Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run. GPs and nurses followed professional guidelines to provide tests, reviews and treatments in accordance with national guidelines.

Staff were qualified to provide the range of treatments patients needed. A high proportion of nurses for the population were employed to give patients the time they needed for assessment and treatment. The practice was using innovative and proactive methods to improve patient outcomes and it was developing links with other local providers to share best practice.

Information for health promotion was available. There were plans to improve presentation and improve signposting to other services.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients told us they found GPs and nurses to be kind and compassionate. They had received a friendly welcome from reception staff. They felt there had been good communication and they had been treated with care and respect.

Consultations and treatments were carried with due regard for people's privacy. A chaperone service was provided when appropriate.

Summary of findings

Patients told us they were included in the decision making process about their care. Systems were in place to identify and support patients' carers and to involve them in care planning when this was appropriate.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

On-going efforts were made to evaluate and improve the appointments system and access for patients by phone and via the internet to appointments, advice and repeat prescriptions.

Health care services were organised to provide and review care in accordance with the needs of the patients.

The patient participation group was developing ideas and giving support to the practice. They were well supported by the practice manager but support from GPs had lapsed.

There was a system to respond to and learn from complaints received by the practice.

Are services well-led?

Good

The practice is rated as good for being well led.

The practice took a leading role in the area, promoting collaborative working between practices and teams.

Lines of communication were clear and there were regular meetings to keep staff informed and updated. An active patient participation group was supported, although they needed improved liaison with GPs.

Training and staff development was promoted for the wellbeing and improvement of patient care.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

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

Nationally reported data showed the practice had good outcomes for medical conditions commonly found amongst older people. The practice offered holistic and patient centred care to meet the needs of the older people in its population. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with greater needs.

The practice followed good practice guidance in providing a named GP for all patients over the age of 75 years, providing flu vaccines for all over 65 and shingles vaccinations for patients in the specified age range.

Annual medication reviews were carried out as appropriate. Carers were supported to identify themselves and offered health needs assessments and reviews by staff trained for this purpose.

The practice worked with the community Integrated Care Team for elderly patients, using an integrated referral pathway. GPs worked with the intermediate team to integrate care of patients recovering from an illness or operation, following time in hospital. They provided support to patients in care homes, including a regular visit to a nearby care home with nursing.

Wheelchairs were available to enable patients to access the practice, a stair lift to the first floor, and ground floor appointments offered to suit patients' needs.

People with long term conditions

Good

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

All these patients had structured annual reviews to check their health and medication needs were being met. Named GPs took the lead with diabetes, hypertension and respiratory diseases, in recognition of the needs of the local population. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients were given a verbal care plan which may not be recorded. There was no written care plan for diabetic patients. Following chronic obstructive pulmonary disease (COPD) or asthma checks, patients were given a hand written care plan in a pre-printed booklet but the care plan was not scanned into the patient record.

Summary of findings

The practice provided speciality clinics and services for chronic disease management such as asthma, COPD, diabetes, ischemic heart disease, stroke, dementia, rheumatoid arthritis, mental health, epilepsy, warfarin monitoring, thyroid disease, cancer care. Trained nurses offered 40 minute appointments for health care reviews, allowing up to an hour for patients with multiple conditions.

A register was kept of patients who were at risk of unplanned admission to hospital, including patients who had recently been discharged. Their care was planned proactively, reviewed in a timely manner, and checked at the fortnightly 'unplanned admissions' meetings. This multi-disciplinary meeting incorporated Gold Standard Framework care planning for patients needing end of life care.

Self-management plans were encouraged and patients were supported into expert patient programs, such as a 'Breathe Easy' group for patients with COPD with advice on the practice's website to enable patients to access training for self-help. However, information about local services was not displayed effectively in the practice to signpost patients to available services.

Families, children and young people

Good

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

Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children, and pregnant women who had a sudden deterioration in health.

Pre-pregnancy counselling was provided, as were postnatal checks, new born baby checks and post natal baby checks. A midwife visited weekly to provide a clinic and there were regular links with the health visitors.

Nurse practitioners received referrals from the midwife, and provided treatment for sick children and support for new parents. Patients could refer themselves directly. They provided targeted support for teenagers and young adults with issues particular to this group regarding mental health, sexual health and pastoral support.

Summary of findings

A nurse practitioner took the lead for Child Protection, and all GPs were working to level three Child Protection training. All staff knew who to speak to should they have any concerns.

The practice worked regularly with the children's hospice. The registered manager of the practice was the Medical Director of the hospice and three GPs worked there too.. The practice had high standards of knowledge and understanding of palliative care.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Pre-booked appointments were available every Monday until 7:30pm. Health checks for the over 40s were offered, plus work related medicals. ECG tests, ambulatory blood pressure (BP) tests, and spirometry were available on the practice and BP machines were available to borrow for patients to monitor themselves over an agreed period. Practice nurses provided smoking cessation groups and one to one sessions. This was offered flexibly, people of working age could get an appointment any time.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and produced care plans. The practice offered longer appointments for people with learning disabilities. Support was provided for people with learning disabilities living in care homes. Mentoring and support was provided, including a close working relationship to help support complicated and vulnerable young people.

Promotion of access to health screening for these patients, for example, cervical screening, weight and lifestyle management, with knowledge and understanding of issues surrounding patients giving informed consent.

Summary of findings

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. The GP who was the registered manager took the lead role in safeguarding vulnerable adults.

Staff experience of patients from ethnic minorities was that some older patients spoke no English, but came with younger family members who translated for them. A language line was available, but had not yet been used.

People experiencing poor mental health (including people with dementia)

Good

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

Patients with mental health problems were offered an annual check of their physical health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Assessment for linked problems with drugs and alcohol had been carried out. The practice had in place treatment escalation plans for patients with advanced dementia.

Staff had received training on how to care for people with mental health needs and dementia. There were links with mental health services. The Depression and Anxiety Service (DAS) provided counselling within the practice. Independent counselling services were also hosted by the practice, including cognitive behaviour therapy (CBT) and as trainee counsellors worked here, the service could be offered to some patients at no cost.

Summary of findings

What people who use the service say

Patients told us they had found GPs and nurses to be very kind and compassionate, and reception staff were on the whole friendly. Patients thought the practice was well organised, and often found their own GP was good at communicating with them about their care needs and treatment options. Patients said they felt they had been listened to.

One patient said they were more than happy but concerned the practice would be stretched when the planned new housing scheme was built. People told us that the new telephone system worked for them, and that their experience was that test results came back promptly. They accepted that if they needed an appointment on the same day it might not be with their named GP. Patients had found the triage system worked well and resulted in them being given an appointment with an appropriate person.

The patients participation group (PPG) said they felt well supported by the practice manager but the GPs had not yet engaged with them effectively. They recognised the challenge they faced in developing their skills and recruiting a wider range of patients, in order to raise their credibility and become an effective representative group. They had a series of proposals to help the practice improve patients' experience.

They found that although some information was displayed in the public areas, the PPG had not found the practice had been proactive in gathering and presenting information in a way that was useful for signposting patients to services. They had proposals to take this forward.

Outstanding practice

The practice had well above average clinical staff numbers for their population with 22 hours nursing provided per 1,000 population, with two nurse practitioners, four practice nurses and four health care assistants. This meant that nurses could offer patients appointments of 40 minutes to an hour to consider care and management of patients' chronic conditions. The nurse team leader made home visits where appropriate to discuss results of tests and review the care of frail and ill patients. Training for the health care assistant meant that one now was able to support the GP in minor operation, a second was trained for wound dressing and a third was a phlebotomist.

Fremington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team of specialist advisors included a GP, practice manager and expert by experience, the latter being a person who has personal experience of using or caring for someone who uses this type of service.

Background to Fremington Medical Centre

Fremington Medical Centre is based at 11–13 Beards Road, Fremington, Barnstaple, Devon, EX31 2PG. It is developing collaborative working with a practice in nearby Barnstaple.

Serving 6,500 patients are five GPs (one woman and four men). There are two nurse practitioners, four practice nurses and four HCAs. The practice has well above average clinical staff numbers for their population. A large proportion of registered patients are older people, so there is a high level of need with respect to long term conditions and complex needs. The population is quite stable and includes young families and working people.

They are a training practice whose current registrar is on maternity leave.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, counsellors and midwives.

The surgery is currently operating a telephone triage appointment system where a GP will ring the caller back following a request for an urgent appointment. Patients with urgent needs will be seen the same day for such problems as severe pain, acute infections and deterioration in previously established conditions, for example, asthma, but they may not be available with a specific GP as the duty GP will meet these needs. When the GP rings back it might be found that the problem can be dealt with over the phone or that a GP or nurse's appointment may be more appropriate. The appointment will then be made by the GP for a mutually convenient time. Patients were asked to phone before 11 am for a morning call back and by 4.30 pm for an afternoon call back.

Appointments with the practice nurses and the phlebotomists can be made directly via reception. A telephone appointment can be requested on the day with a practice nurse or nurse practitioner.

The telephone lines are open from 8 am to 6 pm Monday to Friday and an evening surgery operates on Mondays from 6.30pm to 7.30 pm by appointment.

Appointments can be planned ahead by phone or on-line.

Out of practice hours, patients are directed to an Out of Hours service delivered by another provider.

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.

This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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 14 October 2014. During our visit we spoke with three GP partners and a locum GP, the practice manager and a range of staff and spoke with patients who used the service. We met with members of the PPG who came in to meet us, and reviewed comment cards where patients had shared their views and experiences of the service.

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 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)

Good

Are services safe?

Our findings

Safe track record

The practice manager received safety alerts, assessed them for significance and distributed them to staff. There was a requirement for health care professionals to acknowledge significant alerts. The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The computer had a system that raised interaction alerts for medications.

The practice had a system in place for reporting, recording and monitoring significant events.

Records were kept of significant events. There was evidence that appropriate learning had taken place and that the findings were communicated to relevant staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There was a policy to give staff guidance. The practice had implemented the new documentation from NHS England, to structure learning with respect to significant events. Significant event meetings were held quarterly and action points and evidence of learning recorded and circulated to all staff, for example, following an incident when paramedics had been called to a patient who had collapsed. The patient had failed to respond to GP letters. It was a significant event because of a possible diabetic diagnosis. Action was taken by the practice to make sure the GPs were aware when patients had not attended for their appointment, so they could decide if follow up was required.

We found the practice had a high threshold for reporting of significant incidents events externally e.g. to the Clinical Commissioning Group (CCG). None had been considered sufficiently serious to escalate although patient care had been affected. Some had resulted from shortfalls in other services. We saw evidence of a challenge to poor practice in a local hospital however this was not reported to the CCG. The registered manager agreed to send alerts to the CCG when shortfalls in other services needed to be addressed.

Reliable safety systems and processes including safeguarding

The practice had policies to give staff guidance on child protection and safeguarding vulnerable adults which included the contact details should staff need to raise a concern. Staff felt that safeguarding training had heightened their awareness. A nurse practitioner was lead for child protection and a GP took the lead role for safeguarding vulnerable adults. They had both achieved level three in training and had experience of raising concerns. GPs were all working towards level three. Practice nurses, health care assistants, the practice manager and a staff member had achieved level two. Staff knew who the safeguarding leads were and what they would do should they have a concern. During a recent partners' meeting GPs had requested training in dealing with domestic abuse, so they could provide better support for patients when necessary.

The practice manager agreed to update the policy to include guidance for staff to follow in the event of an allegation against a staff member being received.

The recruitment policy had been followed effectively with references and disclosure and barring services (DBS) checks obtained. GPs had not all kept the practice manager informed of their dates of revalidation or medical indemnity cover that would help her assure safe running of the practice.

A chaperone was offered to accompany patients when consultation, examination or treatment was carried out. A chaperone is a member of staff who acts as a witness for a patient and a medical practitioner during a medical examination or treatment particularly of an intimate nature. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required.

The practice operated a violent patient system whereby people who had acted aggressively within locality practices could receive medical attention when necessary with security in the local hospital.

GP consultation rooms did not have locks. We saw that sensitive information was on occasion left unattended.

Medicines management

The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. A GP took

responsibility as lead for prescribing within the practice and attended prescribing meetings with the pharmacist, reporting to partners meetings. The practices had recently worked on their prescribing performance for non-steroidal anti-inflammatory drugs (NSAID), high risk antibiotics and hypnotic prescribing and were average performers in the locality.

The practice nurse team leader managed the medicines used in the practice. The medicines were kept securely. Records were kept of deliveries and medicines used. GPs came to this secure store to collect medicines as needed such as injections for joint pain. The GPs had their own book to record some medicines that only GPs administered, including which patient it had been given to.

All of the medicines we saw were in date. Storage areas were clean and well ordered. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. This meant the cold chain and effective storage was well maintained. We looked at the storage facilities for refrigerated medicines and immunisations.

The fridge temperatures were recorded by staff at 7am daily. A notice was displayed on the fridges to inform staff of the safe temperature range. Staff had received training on the controls to the max/min thermometer. A trained nurse checked the fridges and records monthly to ensure the vaccines were stored safely so they would be effective for patients.

Some GPs took no emergency medicines on home visits. One had medicines that were past their expiry date but rectified this immediately. Some GPs had given flu vaccines while on a home visit. They had not carried an anaphylaxis kit. The GPs and practice manager agreed that a policy was needed for carrying medicines on home visits and they would meet as a team to draw up a risk assessment.

Cleanliness and infection control

Patients were happy with the cleanliness of the practice. An external company was contracted for environmental cleaning. They kept records and maintained their cleaning schedules up to date. The practice monitored their performance by visual inspection and reporting.

A trained nurse was the practice lead for infection prevention and control (IPC). She carried out an IPC audit, identified shortfalls and introduced improvements as a result. These included new soap dispensers and disposable curtains around treatment couches with dates of when they were new so they could be replaced after a year if not necessary before. Work tops and floor surfaces were in good condition with smooth surfaces so they could be kept clean. Sections of couches that had split had been replaced. Hand washing posters had been displayed in every GP and treatment room. The treatment rooms had been cleared of clutter. This audit on IPC that had been carried out in February 2014 with such positive results had been retained as an annual review.

Personal protective equipment (PPE) was provided in each room. Specimen handling training had been provided for administrative staff. There was information for staff about what they must do if they suffer a needle stick injury, with a check list and form provided for them to take to Occupational Health. However, staff were better protected now, with safer equipment making these injuries unlikely. At a team meeting the IPC lead demonstrated the spillage kit for bodily fluids, including administrative staff so they were aware.

Staff awareness about patients with infectious conditions had been raised. Nurses and administrative staff had used a team meeting to discuss patients arriving with infectious conditions, including people with leg ulcers who have MRSA, people with vomiting and diarrhoea. They were asked to wait in a room for their own comfort and to protect other patients. The room was cleaned between patients.

The practice had moved to a new contract for the collection of clinical waste as of October 2014. All schedules and documents were in place. Nurses took the bags of waste, plus sharps boxes and infectious substances box to a locked cupboard, from where cleaning staff took them to the locked external bins.

Equipment

We saw that equipment had been PAT tested and professionally calibrated as necessary under a contract. A comprehensive schedule and log of practice equipment was maintained and servicing was up to date. This included, for example, the Doppler machine (showing blood flow) and blood pressure monitor.

The electrocardiogram (ECG) machine was sent away to be serviced annually, with another machine provided for patients' use in its absence.

Good

Are services safe?

Staffing and recruitment

Staff worked flexibly to ensure that appropriate staffing levels were maintained in priority areas. For example, the practice identified the pressure point between 8am and 9am, when administrative staff supplemented the reception team to take telephone calls from patients.

There was a formula in place for management to ensure sufficient appointments were offered. When there was a shortfall in GP availability, action was triggered for a locum to be engaged.

The practice had a suitable policy with respect to recruitment and the process had been followed. All partners were currently included on the Devon, Cornwall & Isles of Scilly medical performers list. Criminal record checks using the disclosure and barring service had been obtained during recruitment and references had been received to ensure that employees were safe to work with vulnerable people. There was a register for clinical staff showing all were up to date with their immunisation against hepatitis B to protect themselves and patients. There was not any central register of GPs' appraisals, revalidation and medical indemnity cover.

Monitoring safety and responding to risk

An adverse weather policy was in place. Staff and GPs had demonstrated their commitment to getting in to the practice in adverse conditions. The practice had also purchased a suitable vehicle to bring staff in to work and transport staff to necessary home visits.

There was a business continuity plan which had been evidenced and reviewed six monthly. The close working arrangement with a neighbouring surgery provided support to both practices in the event of any major incident. Practices were in discussion over more collaborative working and some overarching management systems were in place. There had been no major incidents.

Fire risk assessment, emergency action plan, training log and alarm testing log all were all in place and up to date. The practice had held an annual fire evacuation drill. A recent 'false alarm' resulted in an evacuation which turned out to be the security alarm heard sounding, not the fire alarm. This was discussed at a significant event meeting which resulted in fire marshals being appointed, zones being established and the plan updated.

Arrangements to deal with emergencies and major incidents

All GPs, practice nurses and health care assistants had all received annual updates in cardiopulmonary resuscitation (CPR) and anaphylaxis. Non-clinical staff received three yearly updates. New starters had been sent to attend updates at other practices when necessary. Records were maintained and up to date for all staff.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to regain a patient's heart rhythm in an emergency).

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice followed the National Institute for Health and Clinical Excellence (NICE) guidance and had formal meetings to discuss latest guidance. For example, at a recent GP partners' meeting the new pathway was introduced for patients due any cervical, breast or bowel screening.

Health care staff told us they could bring any case or query to GPs informally at the daily coffee meeting, which they found 'invaluable'. Staff told us that the different teams worked well together, which promoted good practice in needs assessment for patients. The nurse practitioner said that GPs would see her patients immediately if necessary, for diagnosis and treatment.

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.

Management, monitoring and improving outcomes for people

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The QOF data for this practice showed the practice performed well in comparison to other practices within the CCG area, achieving just 0.5 point short of maximum in 2013/14. This practice was not an outlier for any QOF (or other national) clinical targets. Good practice was shown by the high proportion of patients with diabetes who had a record of a foot examination and risk calculation within the preceding 15 months and also of patients with mental or physical health problems who had been offered support within 15 months.

Patients with long term conditions were invited for an annual heath check. Nurses offered 40 minute appointments, allowing longer for patients with more than one condition. Practice nurses had taken lead roles with either diabetes or respiratory problems. GPs took on lead roles to take responsibility for providing expertise keeping up to date with best practice, on coronary heart disease, asthma, chronic obstructive pulmonary disease (COPD), hypertension and diabetes. This recognised the needs of the locality.

A recent initiative from NHS England encouraged the practice to focus on high risk patients. Multi-disciplinary meetings were held to consider in detail the needs of patients at risk of an unplanned admission to hospital. There had not yet been an audit to check the effectiveness of the new arrangements.

GPs carried out audits of aspects of their work. For example, the practice had recently worked on their performance for NSAID, high risk antibiotics and hypnotic prescribing. They found they were average performers in the locality. One GP was planning to undertake audits for coeliac screening in irritable bowel syndrome (IBS) patients and prescribing practice with respect to a painkiller. Nurses had carried out audits, for example an audit of their treatment of leg ulcers. This had led to conclusions about assessments and recalls that could improve outcomes for patients.

GPs in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date.

Effective staffing

The registered manager told us the practice was pleased to employ 22 hours nursing per 1,000 of the population which was considerably higher than average provision of nursing care, because they considered this good practice to provide for the needs of their patients.

Nurses told us of the service they were able to provide. The Nurse team leader made home visits, for reviews of patients' care. Community nurses visited the patient to take a blood sample, and when the results came through the nurse visited to discuss any implications. Nurses could offer appointments of 40 – 60 minutes for the annual health review of the care of patients with complex needs.

The nurse practitioner told us they could give patients the time they needed and also had 30 minutes per day to check results from the laboratory and phone patients to discuss the results. Patients told us they got their test results promptly.

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a

five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. However, there was no central log of appraisal or revalidation for GPs in the practice.

Staff were well supported to attend training for example, nurses attended diabetes training. Health care assistants (HCAs) had been funded to achieve qualifications and extend their skills, for example, one HCA now supported a GP during minor operations, another was qualified to do wound dressings. Another had qualified as a phlebotomist. This provided the skills needed for patients' care.

Working with colleagues and other services

GPs and the practice manager worked actively with other practices in the locality. They were working on closer integration and sharing of staff with a practice in Barnstaple. The practice had been an early adopter of pilot schemes for example, electronic hospital letters, in alignment with neighbouring practices, to improve the experience for patients.

Health visitors and midwives, who previously were based at the practice, came regularly to use the premises, but were no longer attached, so attention had to be given to good communication. They told us communication with the Community nurse team leader was good and made a useful contribution to the shared care of frail and vulnerable patients. They considered the palliative care meetings worked well with good input from aligned staff to provide good integrated care for people at the end of life. They met with the nurse from the hospice every two weeks.

The practice fostered links with services for patients with mental health problems. The Depression and Anxiety Service (DAS) provided counselling services from the practice. Other counselling services were provided here, including cognitive behaviour therapy (CBT). Trainee counsellors worked at the practice which meant that a service could be offered to some patients at no charge.

Staff at the practice had strong links with some care homes. One care home provided a service for people with challenging behaviour, who might have a mental health problem and/or learning disability. A GP who had professional experience of working in a service for young adults with mental health problems took the lead for this work. A consultant psychiatrist was involved. The practice liaised and provided repeat prescriptions, and conducted their annual health checks.

The system in place for giving results was to contact the patient when there were implications from any test result, but otherwise not to provide feedback. Patients could phone if they were worried. Patients who spoke with us said they were anxious while waiting for a result, and would not know whether a specimen had gone missing. The registered manager told us they were considering a proposal to write personalised letters to patients, telling them when their condition had improved. The nurse practitioner said when she referred a patient for an ultrasound scan, she asked them to phone her for their result. The nurse reserved time to discuss results with patients to ensure they understood them correctly.

Health promotion and prevention

New patients were asked about their medical history and invited for a medical assessment. Seasonal work was being carried out at the time of this visit as it was time for certain patients to receive their flu vaccines.

The members of the patients participation group (PPG) who met with us offered to take on a role in improving the visual display in the waiting area of the practice. Although information was available, it was not presented in a way that was useful to patients and did not provide clear signposting to services. One PPG member pointed out that information about the flu vaccinations was only displayed within the practice. Patients not needing to come into the practice might miss out. They might consider advertising their flu vaccination sessions in the local paper.

A PPG member pointed out that keeping the website updated and easily accessible to patients took considerable time, and more time than the member of staff given this role had available. A proposal for information screens in the waiting rooms was being considered at the time of this inspection. The practice planned to signpost patients to other health care advice providers about symptoms and conditions, for example, diarrhoea that in the short term the patient could treat without coming into the practice.

Practice nurses provided smoking cessation groups and one to one sessions. People of working age could make an appointment any time, and not wait for a group.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with six patients using the service and a further two completed our comment cards. Patients told us they found GPs and nurses to be kind and compassionate. They had received a friendly welcome from reception staff. They felt there had been good communication and they had been treated with care and respect. Some patients paid tribute to particular nurses and GPs who had listened to them effectively.

The practice's own patient survey had recorded a decrease in satisfaction for the respect shown for patients' privacy by reception staff. Phone calls were taken in a back room and not the front desk, so patients in the waiting area would not overhear any discussion. A separate room for discussion could be provided on request. The practice kept this issue on their action plan for the year ahead due to the patients' perceptions.

Data from the national patient survey showed the practice was rated slightly above average for its satisfaction scores on consultations with GPs and nurses, with practice respondents saying the last time they saw or spoke to a GP or nurse they were good or very good at treating them with care and concern.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There were no locks on consulting room doors and we saw a computer left unattended which could potentially have led to a breach of confidentiality.

Posters displayed in consultation rooms informed patients they were able to have a chaperone should they wish. A chaperone is a member of staff or person who accompanies a patient during a consultation, medical examination or treatment. Nurses and health care assistants carried out this role which was to reassure and observe that interactions between patients and GPs or nurses were appropriate.

Care planning and involvement in decisions about care and treatment

The practice was in the process of providing care plans for all its patients who had a learning disability. It had been agreed in a partners meeting in July 2014 that all were given a health action plan as they leave annual review. There was no written care plan for diabetic patients. For COPD and asthma checks patients were given a care plan which was handwritten on a pre-printed booklet but not scanned into the patient record. Treatment escalation plans were drawn up for people receiving end of life care, in discussion with family members and carers where appropriate.

Three GPs carried out minor surgical operations. Patients recorded their consent on a paper form that was scanned to their computerised patient record.

When referring a patient to hospital, GPs used the 'choose and book' system for referrals in consultation with the patient. This ensured the patient knew the service had been requested, as well as ensuring it was at a place and time that suited them.

GPs and nurses had dealt with issues of patients' capacity to give informed consent. For example, if a patient with a learning disability was unable to give informed consent to a procedure for health screening, learning disability liaison nurses were available for support, and could arrange meetings with appropriate healthcare professionals and family members or carers to agree on the person's best interest. The ability of young people to make decisions about consent, for example about contraception, known as Gillick competence, was assessed by GPs and nurses. A nurse told us that young people often come in with a parent to discuss these issues.

Patient/carer support to cope emotionally with care and treatment

Minutes from regular care meetings showed that the nurse practitioner practice manager and a GP from this practice met with the hospice nurse and community nurse to review the care of people receiving palliative care. This recorded patient's needs for emotional support, including the support needs of their carer and family.

A health care assistant was carers' champion for the practice. They were trained to carry out thorough assessments of carers' needs and sign posted people to

Good

Are services caring?

services that could help them. The health checks provided for new patients included identification of carers. This had included helping patients see themselves as a carer, who could therefore be given information and support in respect of the person they were caring for. A leaflet with advice for carers was available on request at reception.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had done extensive work on their appointment system. They operated a full telephone triage system for patients who need urgent GP appointments. This had improved both continuity and access, because all patients with urgent needs were seen on the day by the duty GP, so other GPs were able to see their regular patients at booked appointments. Requests for home visits were prioritised by GPs. One patient with a long term condition described how the system helped them. Their GP listened to their account of their varying condition, reviewed their medicines regularly, and the triage system meant they only needed to see the GP occasionally, as telephone calls back meant they did not need to attend. They said they felt the GP cared about their well-being.

Because the practice had a good nurse to patient ratio, nurses were able to offer 40 – 60 minute appointments to patients with chronic conditions. Annual reviews were offered and when a patient had more than one long term condition, patients were reviewed at one appointment, described as a 'one stop shop'. This was to consider the health care needs of the patient as a whole, as well as keeping transport to appointments to a minimum.

Health care professionals had extensive knowledge, experience and understanding of palliative care, for patients of all ages. There was a clear process for end of life care. 'Just in case' medicine prescribing templates were used. The practice met with the hospice nurse every second week and worked with the community integrated care team for elderly patients, using an integrated referral pathway.

The patient participation group (PPG) had around 12 members, none of whom were under 40 years of age or of ethnic origin. Nine members, including the chair, met with us during this inspection. They told us they were keen to include more patients as they needed a more representative group, and they were considering diverse ideas for recruitment. A PPG road show was arranged for 11 and 13 November. The group appreciated the support they had from the practice manager but felt there was insufficient contact with the partners as the GP who had been detailed to support this venture had not been able to attend their meeting for over a year. GPs recognised this lack of engagement was a weakness.

The PPG had positive suggestions for supporting the practice, in particular with communication and information sharing with patients, some of which had resource implications. Their proposal for a power point presentation on a loop in the reception areas was currently under consideration by the practice. The PPG produced an action plan in April 2014. Following patient feedback, improvements were made to music in the waiting room and high level waiting room chairs were ordered.

Access to the service

The reception desk was accessible and welcoming. There was an auto-check-in, which was at a good height being not too high for patients in wheelchairs, as was the foam hand cleaner. The booking-in machine was new, but the receptionist was patient and explained to patients how it worked.

A computerised system online service provided speedy access for appointments and repeat prescriptions for patients who were comfortable using the internet. Otherwise patients could visit or phone to book appointments with their named GP, or to enter the triage system if their need was urgent. Some patients told us they found the triage system was working well and they had been seen by an appropriate person. GPs were finding that the appointments system was working well, enabling them to see patients who needed an urgent appointment, while maintaining their ability to see their regular patients.

PPG members considered that it was not well understood amongst patients that they could not always see a GP when they wanted, although a GP was always available when needed. They were keen to help spread this knowledge and understanding. The patients' survey report, published March 2014, expressed disappointment that satisfaction with telephone access had decreased. The practice manager thought this could be attributed to high volumes of incoming calls for prescription requests. PPG members offered to teach patients how to book on-line for a telephone call-back and how to log in and set themselves up for online repeat prescriptions, to take pressure off the phone lines.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had taken part in a 'Primary Care Foundation' study which analysed the appointment capacity. They met with the researchers in May 2014 to look at recommendations to improve access by telephone. Any agreed proposals would be added to the action plan. This showed they were continuing to look for improvements in patient access.

The ground floor was level and patients who are unable to climb stairs or use the stair lift were offered appointments downstairs. The disabled toilet had no emergency cord or enough room for an independent wheelchair user to transfer as there was no turning room and the hand wash basin was in the way. The door lock was difficult to operate.

Patients entering the practice appeared to be at ease. The long soft benches were comfortable but there was nowhere to park a wheelchair. We were advised that higher chairs had been ordered, to assist patients who had difficulty in standing.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

The complaints policy was published on the practice's web site and displayed in public areas in the practice. In spite of this patients told us they thought the procedure was not clear and they knew of patients who had not known how to make a complaint. The practice manager received all formal complaints and acknowledged them within three working days. The time limit for formal response was set at one month. Complaints formed part of Significant Event meetings and an annual summary was submitted to CCG. There was no 'live' register in place for ease of review but minutes of meetings were shared for learning points. The complaints review held in July 2014 showed that complaints received over the previous year had been investigated with care and responded to in a timely way.

Staff told us that if they found anything was wrong, they discussed it with the practice manager. If appropriate, it would be included on the agenda for the significant events meeting. Staff could see these minutes on their intranet for feedback or learning.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice was proud of its level of service provision, employing well above average number of clinical staff for their population. This meant the practice could safely deal with the increasing burden of need and demand. The population they served had higher than average older patients and more patients with complex care needs than average. Patients told us they were more than happy with the service but concerned the practice would be further stretched when new houses were built. The practice was working with local practices to plan to cope with a large expected increase in the Barnstaple population.

The practice was pleased to take a leading role in the locality. The practice was developing integrated working with another practice as well as leading discussions on a wider federated approach to primary care. The registered manager was on the local medical committee (LMC) and was elected onto the General Practitioners Committee (GPC) in July 2014. This is the body that represents all NHS general practitioners in the UK and is responsible for negotiating the GP contract with NHS England. The practice manager was the current chair of the North Devon practice managers' group. Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

The practice had been an early adopter of pilot schemes for example, electronic hospital letters. The practice had close links with the children's hospice, as the registered manager was its medical director. They were proud of the palliative care offered within the practice, bringing their skills to patients of all ages. Palliative care meetings worked well with good input from aligned staff.

Governance arrangements

A schedule of partners meetings both within the practice and jointly with the Barnstaple practice were in place, facilitating closer working arrangements and joint planning. There was evidence of good team working and staff felt supported and valued. Staff were informed of practice business and development through both monthly meetings and informal communications. The nurse team met monthly and the multi-disciplinary meetings to co-ordinate care of patients with complex care needs took place fortnightly. Reception team meetings were held monthly. Meetings were used for introducing procedures and policies to ensure the teams were working in accordance with guidelines. Full practice meetings had been held, including staff training sessions.

The practice had carried out peer review through informal contact between GPs and operated a buddy system between themselves for feedback and advice. We saw examples of advice being sought and shared between GPs. Peer review meetings had been held both within the practice and locality.

The practice used the Quality and Outcomes Framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for Fremington Medical Practice were in accordance with the national average.

Leadership, openness and transparency

Staff communicated a very clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control, a lead GP for safeguarding. There were clear lines of accountability, and each staff member had received an appraisal from their line manager.

Lines of communication were both informal and formal. Any clinical or non clinical issues were discussed amongst staff as they arose. For example, GPs and nurses met daily where they discussed any complex issues, workload or significant events or complaints. Staff told us that felt valued, well supported and knew who to go to in the practice with any concerns.

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

Administrative staff and the nursing team said there was good liaison between the teams, and that issues were discussed between the teams regularly. When staff had a suggestion or an issue to raise, they brought it to the practice manager, who would represent their views or input to the partners at their meeting if appropriate. Staff said the management were responsive to their requests and suggestions.

Are services well-led?

Good

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

The GP who was the registered manager had recorded comments that patients and staff had made about the changes to the appointment system. A working group including nurses and administrative staff had evaluated working practice. The registered manager said he had looked at the GP and nurses' work load, but they had not yet done a re-audit since the changes to the appointment system. The Patients Participation Group (PPG) had not been involved in designing the triage system, but were interested in helping advise patients in its use.

The PPG met every two months and were actively introducing ideas to help improve the patient experience. For example, they had given constructive feedback about reception staff which lead to provision of customer services training. They felt well supported by the practice manager, but felt a need for increased liaison with the GPs and were unsure of how responsive the practice was to their ideas. They pointed out there were methods for feeding back views to the practice, but no method for auditing for effect. They were keen to improve their credibility as a group, but concerned over availability of resources to achieve their ideas.

Management lead through learning and improvement

Staff had been supported to progress their careers and develop skills needed by the practice. A nurse practitioner had been enabled to qualify and other nurses had been funded to attend training on diabetes.

The practice did not maintain a central matrix to record and demonstrate staff training achievements and needs. Training was discussed individually at staff appraisals and records maintained on personal files. Health care assistants had been funded for training to develop skills for example, one now supported GPs at minor surgical operations, another could do wound dressings, and another was a phlebotomist. We were told that one staff member who started work at the practice as a receptionist, had trained to be a health care assistant and later left to qualify as a community nurse. Nurses were sponsored to attend the quarterly regional practice nurses' forum.