Boutport 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

Boutport Medical Centre was inspected on Thursday 23 October 2014. This was a comprehensive inspection.

Boutport Medical Centre provides primary medical services to people living in the North Devon town of Barnstaple, and the surrounding areas. The practice provides services to a diverse population age group and is situated in the historic heart of the town.

Information from Public Health England shows this practice had more patients with long standing health conditions and more disability allowance claimants and carers than average for England and the population was found to have average levels of deprivation overall.

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

Overall this service was rated as good, with some work that was outstanding and some elements that needed improvement.

Our key findings were as follows:

- Patients could book in advance and see their own named GP, which they liked. Half of all appointments were 'book on the day'.
- Patients with complex problems said they had been shown understanding and kindness and the care, manner and treatment from GPs had been second to none and very reassuring. Patients specifically mentioned the compassion and humour of reception staff.
- The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards and above average with respect to support provided to some vulnerable groups.
- The premises needed considerable maintenance, as the practice was housed in a grade two listed Georgian

Summary of findings

building. A manager was identified as responsible for risk assessment and had carried out a health and safety audit of the service. Not all safety issues had been fully dealt with.

We saw several areas of outstanding practice including:

- A GP from this practice had arranged and produced a successful bid on behalf of the 23 member practices in the North Devon GP provider group, for funding for a single computer system to be used across these practices to help them work together. The bid was under the Prime Minister's Challenge Fund for innovative models of care.

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

The provider should:

- Gather references as evidence of conduct in previous employment of GPs seeking to join the practice.
- The flooring in all clinical areas should be seamless and smooth, so it can be easily cleaned.
- There should be documented protocols in place for chronic disease management clinics that would ensure best practice was consistently followed.

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, however there are areas where it should make improvements.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. We saw examples of improvements that had been introduced due to analysis of a significant event. These events were recorded on the practice's intranet and discussed at quarterly meetings, to ensure learning was shared.

Although there was a suitable process in place to recruit staff, references had not always been followed up.

A named GP took the lead role for safeguarding older patients, young patients and children. This GP had been trained to the appropriate advanced level. Guidance for staff was available within the practice, including the contact details they would need to raise or discuss a concern.

The flooring in all clinical areas should be seamless and smooth, and easily cleaned.

Are services effective?

Good

The practice is rated as good for providing effective services.

A practice intranet was provided to save good practice and clinical information and to share updates and developments in practice with health care professionals.

Nurses and GPs met informally each day and had good working relationships, and were planning regular meetings to discuss clinical issues and new national guidance eg NICE guidelines.

GPs demonstrated good evidence of keeping up to date with their practice and carrying out audits of their work in order to assure good outcomes for patients. Nursing staff made arrangements to cover each other's planned absences to maintain services for patients.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients told us they had been pleased with the high standard of care from GPs, nurses and receptionists and were satisfied with their care and attention.

Summary of findings

Consultations and treatment were all carried out in a manner that maintained patients' privacy and dignity and chaperones were provided if required.

GPs were involved in care planning for the frailest patients and reported increased liaison with family members when a patient lacked capacity to make decisions about their own treatment.

A health care assistant was trained to carry out thorough assessments of carers' needs. They also signposted people to services that could help them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice understood the needs of the practice population and had systems in place to maintain the level of service provided and address identified needs.

Comprehensive information was available to patients about appointments on the practice website. The practice had tried triaging by phone but patients did not like it. The practice had responded by introducing another system. At the time of this visit, patients booked in advance and could see their own named GP, which they liked. Half of all appointments were 'book on the day'.

A person was designated as responsible for handling all complaints in the practice. The staff had discussed the benefits of recording minor concerns and had agreed at a meeting in the week prior to this inspection to implement such a record, to enable a response to be made and recorded and to show up any emerging areas of concern.

Are services well-led?

Good

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

The GPs were enthusiastic about promoting collaborative working. The team was involved in planning for the future and considering options for development.

A successful bid had been made for central funding by the IT lead partner for funding for a single computer system to be used across practices in North Devon to help them work together. Access to shared patient records was to be via smart card by expressed patient consent. This was under the Prime Minister's Challenge Fund for innovative models of care. Health care professionals recognised it was a quality issue for patients that GPs could access other practitioners' records as it helped them provide continuity of care.

Summary of findings

There was a clear leadership structure with named members of staff in lead roles. The senior partner proposed increasing the frequency of partners meetings and holding them weekly. Working relationships between GPs and staff were good, but would be better supported by regular formal communication.

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.

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

GPs aimed to provide a holistic and patient centred approach and provided home visits to frail patients.

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.

Consultations and treatment were always available on the ground floor for patients who found the stairs difficult and appointments were arranged to suit different needs, including extended hours.

People with long term conditions

Good

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

Speciality clinics and services were provided for patients requiring chronic disease management such as with asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Ischaemic Heart Disease, Stroke, Dementia, rheumatoid arthritis, mental health, epilepsy, the monitoring of warfarin (a blood thinning medicine), thyroid disease, cancer care. Patients were given appointments with respective trained nursing staff, combined with a health care assistant for testing as required.

Self-management plans were encouraged, with information about and links into expert patient programs, such as a 'Breathe Easy' group for patients with COPD.

A register was maintained of all patients at risk of unplanned admission to hospital including those who had been recently discharged. Proactive care planning and reviews were carried out in a timely manner.

A 'virtual ward' service was provided for patients with complicated health needs, whose care extended across multidisciplinary teams. Their care needs were discussed at regular meetings. The practice liaised on behalf of patients, with secondary care services such as specialist nurses in respiratory, heart failure, rheumatology and multiple sclerosis.

Summary of findings

Families, children and young people

Good

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

Pre-pregnancy counselling was offered. Antenatal care and maternity services were provided in partnership with midwives who were based in the practice. New-born baby checks were provided as well as postnatal checks for mother and baby.

Childhood immunisations were provided in accordance with the NHS programme with a high proportion of children immunised. Information from NHS England showed that 100% of children aged 24 months received their meningitis vaccination.

The receptionists ensured that families with young children were given appointment times that were convenient to them and appointments were provided the same day to children under five years presenting with a health problem. Regular links were maintained with a health visitor who ran a clinic from the premises.

The patients participation group had provided a baby change facility in a ground floor toilet. In the waiting room there were little chairs and tables for children, with a puzzle.

GPs provided information on sexual health, including promoting chlamydia screening. Contraception, including contraceptive implants was provided. GPs told us of using their professional judgement in accordance with the Gillick guidelines when assessing the competence of young patients to make decisions about contraception in their own best interest. A GP said young patients often came with a parent.

Safeguarding policies were in place and staff had received training in child protection. Health care professionals said they would phone the multi-agency hub and make a referral about any child they had concerns about and knew of the number they could phone to discuss queries.

Working age people (including those recently retired and students)

Good

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

Online access was provided for booking appointments and receiving test results to provide convenience and speed for working people. The practice opened at 7:30am every day for booked appointments. Telephone appointments were available.

Adult health checks were offered for patients over the age of 40. Work related medicals were offered such as those needed for taxi and heavy goods vehicle driving licences. In-house health care

Summary of findings

checks included phlebotomy, ECG, ambulatory BP, spirometry so that patients did not have to travel for these services. Machines were available for patients to borrow to test their blood pressure at home over a period of time.

If referral to secondary care was needed, patients were provided with a choice of care providers through the use of a full choose and book access to Devon services.

People whose circumstances may make them vulnerable

Good

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

Staff considered care of vulnerable patients to be a core part of their service because of their town centre location. Staff said they had made appointments for people who did not have a home address but needed medical attention. Support was provided to patients who had suffered domestic violence.

The practice supported the work of the Devon-wide adult substance misuse service. There was a high incidence of addiction in the area. Some GPs were accredited for shared care prescribing.

A register was maintained of patients who had a learning disability and they were offered annual health care checks.

The local population was predominantly white British. Use of a language line was available in case of need. Staff told us that local pharmacies directed holiday makers and other people away from home to this practice. When homeless people arrived, needing medical attention, they were registered and offered an appointment.

People experiencing poor mental health (including people with dementia)

Good

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

Patients with mental health problems were offered annual checks of their physical health. They were assured same day access to medical care if their health deteriorated.

Links were being promoted with the Depression and Anxiety Service which was based In a neighbouring property. Workers from that service used practice rooms to provide counselling services for patients at the practice.

Mental health services were actively promoted in the information screens provided in both waiting rooms, and leaflets about services and support groups were available.

Summary of findings

What people who use the service say

We spoke with ten patients either in the practice or by telephone. The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. Twelve patients submitted comment cards. Three members of the patient participation group (PPG) came to meet us and another sent us their views in a letter.

Patients told us they had been pleased with the GPs' high standard of care and said they were always provided with excellent advice and service. Patients said that when necessary they had been referred immediately for other services and they had found GPs and staff at Boutport Medical Centre to be kind, friendly and thoroughly professional.

One person said that they had complex health care problems and had found the care, manner and treatment from the GPs had been very reassuring. The consensus was that GPs were very caring and never rushed the appointment.

One person was not satisfied with their treatment and told us of a complaint that they had lodged with the practice. We saw that the practice had responded in accordance with their complaints procedure.

More than one person said that on the occasions that they had been to the practice they had been particularly impressed with the reception staff who did what they could to help with good humour and kindness. We also received tributes to nursing staff. Patients said the practice nurses were always pleasant and very helpful in the clinics for diabetes, heart disease or respiratory problems.

People were aware of the challenges of the building. They said that downstairs rooms were always made available when needed.

The PPG members told us they were considering ways to extend the range of patients who belonged to the group. They told us of ideas they had to support the practice and advance the activity of the group.

One patient told us the check-in system had greatly improved but they felt there could be more phone lines. Patients told us they had preferred GPs and said they would book weeks ahead to see them. At the time of this visit, patients could book in advance and see their own named GP, which they liked.

Areas for improvement

Action the service SHOULD take to improve

The flooring in all clinical areas should be seamless and smooth, and easily cleaned.

The practice should gather references as evidence of conduct in previous employment of GPs seeking to join the practice.

There should be documented protocols in place for chronic disease management clinics that would ensure best practice was consistently followed.

Outstanding practice

A GP from this practice had arranged and produced a successful bid on behalf of the 23 member practices in the North Devon GP provider group, for funding for a single computer system to be used across these practices to help them work together. Access to shared patient records was to be via smart card by expressed patient

consent. This was under the Prime Minister's Challenge Fund for innovative models of care. In addition, the practice was developing its intranet to save and share good practice and clinical information.

Boutport Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our team was led by a CQC lead inspector and included a GP.

Background to Boutport Medical Centre

This practice is situated in a Georgian house in the centre of Barnstaple. The building is owned by a charitable trust, the Barnstaple Bridge Trust. Staff had been reassuring to patients who had been disturbed by the retirement and departure of GPs who had provided their care for many years. Five new GP partners now ran the practice, three women and two men, all part timers. Three practice nurses, a full time health care assistant and a team of administrative staff were employed. The partners said they would like to take trainee GPs but did not have a consultation room suitable for a registrar.

The practice population had increased by 3% in the past year, now over 5,000 people were registered as patients of the practice. It includes higher than average numbers of people living in sheltered accommodation. There is a higher than average number of people involved in drugs and alcohol. In the neighbourhood is a centre for homeless people and a support service for families in difficulties. Patients from these groups come to this practice because it is seen to be friendly and approachable.

The reception staff team had all worked at the practice for many years and knew the patients well. 98% of patients completing the practice's survey had been happy with the reception staff saying they were welcoming and tried to help. Staff told us that the ethos throughout has been to help people. The partners stated mission was to aspire to be patient centred, responsive, to provide quality care and promote wellbeing.

Out of practice hours, patients are directed to the NHS 111 service.

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.

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 23 October 2014. During our visit we spoke with a range of health care professionals and administrative staff and spoke with patients who used the service. We phoned patients, with their consent, after the visit and also talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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 used a range of information to identify risks and improve patient safety, for example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. A nurse took responsibility for COSHH assessments (control of substances hazardous to health). Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Reviews and audits were carried out to check the safety of medicines and equipment used in the practice. For example, GPs met during September 2014 to discuss the pregablin audit. They recognised the opportunity to improve their recording of the benefit of the medication and the need to systematically review the on-going benefit.

Learning and improvement from safety incidents

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

Good learning was demonstrated from significant event reviews. For example, a recent meeting discussed a delay that had been identified in notifying a patient of their X-ray result. The line of communication was investigated, and it was found that the requesting GP was on annual leave for two weeks and the task was not reallocated until a week later. This episode was used to raise the awareness of the entire team to the chain of communication to reallocate results in the absence of GPs.

A system was in place to record accidents. In October 2013 a fall on the stairs was recorded. Analysis had led to the installation of the second bannister to improve patient safety.

The practice's policy on significant event reviews required recording of what went well, what could have been done better and what were the root causes. The newly appointed practice manager had plans to introduce a system to also capture less significant events to enhance the team's learning. Significant event review meetings were held quarterly and included all practice staff. Although GPs and nurses had regular informal contact, they met as a group to discuss clinical issues only once a quarter.

Reliable safety systems and processes including safeguarding

The practice had a policy in place for the protection of children and safeguarding of vulnerable adults. The policy had been reviewed in May 2014 to ensure it was in accordance with current practice. It included guidance for staff on what to do in the event of a disclosure, observation of potential abuse and guidance on reporting concerns including whistleblowing. We did not see that clear guidance was available for staff on how to respond to an allegation being received about the practice.

Patients told us they felt safe at the practice and staff knew how to recognise signs of abuse in older people, vulnerable adults and children. A named GP took the lead role for safeguarding older patients, young patients and children. This GP had been trained to the appropriate advanced level. A group session had been held for the whole practice to study the DvD on safeguarding. All GPs were working towards level three training. Guidance for staff was available within the practice, including the contact details they would need to raise or discuss a concern.

Staff who spoke with us knew what to do and how to identify potential abuse and that the contact number to raise a concern was on the practice's intranet. Regular meetings took place with the midwives and health visitors to discuss concerns about children.

The practice had a written policy and guidance for providing a chaperone for patients. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they felt one was required. Nurses and reception staff acted as chaperones as required and training for chaperone duty was provided in March 2014. When staff made an appointment for an examination they knew was intimate, they would offer the service, so they could be ready with sufficient staffing. If it was not pre-planned, the GP would offer the service, then ask a nurse, then ask reception staff, and if none were available, would request another appointment.

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. There was a

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Controlled drugs were stored and recorded safely.

A GP took responsibility as lead for prescribing practice. We saw that an audit of prescription for a medicine used for managing pain was discussed at a GPs' prescribing meeting, with agreement recorded on how to improve documentation and benefit for patients.

There had been a successful introduction of electronic prescribing. We did not identify any issues with medicines management.

Cleanliness and infection control

The practice had a full and comprehensive policy on infection prevention and control (IPC) were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. The policy required an annual audit and assured the provision of resources.

The practice had appointed the nurse team leader as lead for IPC. She was trained to provide advice on the practice infection control policy and carry out audits and staff supervision. All staff received training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit of IPC practice and of clinical waste disposal in clinical rooms. Action for improvements had been identified and completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. The partners had discussed the results of an audit at a meeting in September 2014 and agreed priority areas for decorating, flooring of treatment rooms and de-cluttering of treatment rooms and GP consultation rooms.

Good practice was evident, including new curtains around treatment couches, labelled with the date of their installation. Sharps boxes were kept out of sight in a cupboard. Most instruments used in treatments were for single use. 'Minor Ops packs' were sent to the hospital for sterilisation. They were returned bagged and dated with the expiry date and staff ensured they were not used after that date without repeat sterilisation.

We looked at the waste disposal audit done by the IPC lead, and the actions taken in response. Domestic bins had been replaced with fire retardant pedal bins, and made available in each clinical area. Staff were given guidance about the appropriate disposal of items. Staff were reminded to sign and date sharps bins when they were assembled, so they could see how long they had been in use. A system had been put in place to check these. A repeat audit was planned.

The flooring in a first floor treatment room was carpeted, and the ground floor treatment room was partially carpeted. This meant that flooring in clinical areas was not always seamless and smooth, slip-resistant, easily cleanable or appropriately wear-resistant. A recent partners' meeting considered obtaining quotes for new flooring. Records from the cleaning company showed that they last cleaned the carpets in 2012. However, a new schedule had been drawn up for the cleaning company, who had recently started to record on a schedule that they vacuumed the carpets every day. They also replenished all soap dispensers and paper rolls used for covering couches and disinfected the bannister. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Sills, skirting boards and ledges were cleaned weekly. We saw the standard of cleaning was good although some surfaces of sills and pipework were discoloured and not smooth which affected the appearance. The IPC audit had raised the issues of surfaces of walls and pipework in treatment rooms, and redecoration had been discussed at a partners' meeting. Funding was being sought to replace a rusty radiator in a toilet used by the public.

A charitable trust was landlord of the premises and had responsibility for Legionella testing which had not yet been carried out. The land lord had carried out a risk assessment for asbestos.

Equipment

Equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

Good

Are services safe?

Pulse oximeters were provided in every treatment room, which was good practice to check the levels of oxygen in patients' blood and their pulse rate. The spirometer was broken, but funding had been agreed for its replacement. This was needed to help diagnose and monitor lung conditions.

Other pieces of equipment were also identified as needed by the practice, who were looking into buying in consortium with other medical practices in the area. The partners agreed that spending on equipment was necessary but they were looking into how neighbouring practices managed to negotiate good arrangements.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that in most cases appropriate 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 through the Disclosure and Barring Service (DBS) and where no DBS check was deemed to be necessary a risk assessment had been recorded to ascertain any safety issue for patients.

All the partners at the practice were on the Devon Medical Performers List and had therefore had all the necessary clearance checks, though the checks had not been made at the point of entry to the practice. Not in every case had references been taken up from previous employment when a GP joined the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included a health and safety compliance check of the premises. The fire risk assessment, drawn up professionally in 2011, was due for review in 2012 but had not yet been reviewed. The person who had produced the assessment had visited to provide fire training to staff annually, most recently in January 2014. The alarm system had been professionally tested and serviced and tested weekly by staff. Extinguishers had been checked in July 2014.

A leak from a water tank that caused damage to the waiting room ceiling had been recorded as a significant event as patient safety was at risk. An architect had been engaged to assess the risk for patients, assessing that the repair had made it safe but more investigation was needed.

The premises needed considerable maintenance, as the practice was housed in a grade two listed Georgian building. A manager was identified as responsible for risk assessment and had carried out a health and safety audit of the service. Maintenance and improvement options were discussed regularly but as the practice did not own the property, speedy action on repairs had not always been possible. There were several cracks in plasterwork. There was a trip hazard at the threshold of the waiting room on the first floor, a pointed piece of pipework needing a cover and a window without a restrictor in a first floor room used by midwives and health visitors, with access by children. The practice manager agreed to deal with these promptly within her remit.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. A nurse was qualified as a first aider. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Administrative staff all joined mandatory training in resuscitation (CPR). A nurse was qualified as a first aider. Staff on reception had received training in basic life support and they could describe what to do in the event of a person suffering a cardiac arrest, though they would call for a health care professional if this occurred in the waiting room. A flow chart was on the wall to remind staff what to do in the event of a medical emergency. They told me they would phone a nurse, and send an urgent screen message to GPs if a patient collapsed in the waiting room and they had done this on behalf of members of the public who had fallen in the street and needed help.

The practice had a disaster handling and business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. It was available for all staff on the practice's intranet and a copy

Good

Are services safe?

was pinned to the board behind the reception desk for easy reference. Risks were assessed and mitigating actions recorded to reduce and manage the risk, including power failure, loss of essential supplies and winter planning. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Over the past year GPs had developed their use of information technology to promote good practice. For example, a practice intranet was provided to save and share good practice and clinical information and ensure all health care professionals received updates and developments in practice. An example of an up-date in practice was provided by a GP who had attended a seminar where an audit of cancer care was discussed by health care professionals from practices in the area. From this, a risk assessment tool was introduced to help identify patients at an earlier stage whose symptoms might be due to cancer.

Nurses and GPs met informally each day and had good working relationships, but there had not been regular meetings to discuss clinical issues or new national guidance eg NICE guidelines. GPs acknowledged that communication needed to be improved and the practice manager had plans to establish a weekly practice meeting.

Systems were in place to assess risks in newly registered patients. GPs had specialities in long term conditions and supported each other's practice. Members of the patient participation group told us of their contribution in purchasing equipment that helped in assessment and diagnosis. Administrative staff arranged health care reviews for patients with learning disabilities or long term conditions. There was a system to make sure no-one was missed and if patients failed to arrive staff phoned or wrote to them to make an appointment.

Management, monitoring and improving outcomes for people

GPs demonstrated good evidence of keeping up to date with their practice and carrying out audits of their work in order to assure good outcomes for patients. The GP prescribing lead had evidence of audits and reviews within the practice. For example, assessment of the efficacy and management of a medicine used for managing pain resulted in several learning points for the practice. Other examples of clinical audits included a check on prescriptions to patients with chronic kidney disease (CKD) who were prescribed non-steroidal anti-inflammatory drugs (NSAID).The review was noted at a partners meeting and six months later recorded that it had been re-audited, showing that there was no longer any significant prescribing of NSAIDs to the at-risk group. Some audits were available on the practice's intranet but there was not evidence to show that systems were in place to formally share the learning from these audits.

GPs in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They were planning an audit comparing infection rates following minor operations.

Practice nurses ran clinics where they helped patients manage chronic diseases, including diabetes, respiratory diseases and coronary heart disease (CHD). No documented protocols were in place for these clinics that would ensure best practice was consistently followed.

Plans were in place for a regular 'referrals review' meeting between GPs to help learn from each other and to optimise patient referrals to hospital. A new initiative had been introduced by the NHS commissioning board, whereby all admissions had to be reported. The practice had been focussing on review and planning for the care of patients at risk of admission and planned to re-audit admissions to find whether any change had resulted and whether unplanned admissions to hospital were decreasing.

The practice had been involved in discussion with other practices in the area of cancer deaths with the aim of learning from auditing and sharing good practice. Monthly multi-agency meetings were held at the practice to optimise management of complex care and end of life patients.

Effective staffing

Although all GPs worked part time, they managed partners' annual leave cover between themselves, with virtually no use of locum cover, offering better continuity of care to their patients. This had resulted in the waiting time for non-urgent appointments stretching to three weeks during the summer when GPs were on holiday, but had returned back to about a week in advance for the soonest pre-bookable appointments. A locum had been appointed to cover for maternity leave, but not for short absences.

Good

Are services effective?

(for example, treatment is effective)

Between them, GPs had interests in a range of interests, including dermatology, diabetes, child health, contraceptive advice, and ophthalmology, showing a good skill mix. Staff said that some patients found it reassuring that one GP knew so much about eyes.

Nursing staff made arrangements to cover each other's planned absences. For example, when they knew the health care assistant (HCA) would be away, they blocked out nursing time to cover her duties, especially phlebotomy (taking blood), to maintain services for patients.

The best use of nurse resources and development of nursing capacity within the practice had not been assessed. Some clinics were not fully booked, and we were told this provision was under review. There was no nurse practitioner, and nurses did not visit patients in their homes although not contractually prevented from doing so.

Administrative staff said they all knew each other's jobs and could maintain processes effectively and help each other at busy times.

Working with colleagues and other services

Good working relationships were demonstrated between GP partners and other clinical and non-clinical staff. Health visitors and midwives were based in the premises which helped to provide good communication and joint working. They joined a monthly meeting with GPs to discuss any concerns. A physiotherapist worked in the practice two days per week, which was convenient for patients and enabled sharing of knowledge. Other services visited, for example, a retinopathy service came from Exeter regularly. Retinopathy is damage to the eyes caused by diabetes. A service for patients with mental health problems was sited next door, but did not provide a walk-in service. A link was provided on the practice's website.

A monthly meeting was held in accordance with the Gold Standard Framework (GSF) for end of life care. Two or three GPs were involved at each meeting, plus the complex care team, hospice nurse, community matron, occupational therapist (OT), physiotherapist and palliative care nurse but not a social worker. Participants told us these meetings helped them understand the overall needs of the patients. The team referred to a pathfinder's team who helped patients to be cared for at home to promote good care and patient choice.

GPs, nurses and staff all said they got on well, enjoyed working together and had the chance to meet everyone over the course of a week, due to the coffee time meetings. However, there was not a formalised meeting for professional updates. All were open to improvements to communication proposed by the new practice manager.

The practice worked with other service providers to meet patient's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. A robust system was in place to check that results were not delayed and this process had been reviewed recently in response to an identified error.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used SystmOne, an electronic patient record to coordinate, document and manage patients' care. 'Special messages' were uploaded to be available to out of hours providers for complex and end of life care to help other health care professionals to respond in an appropriate way. The practice offered an electronic prescription service, which allowed patients to nominate a pharmacy to get medicines or appliances from.

A GP from this practice had arranged and produced a successful bid on behalf of the 23 member practices of the North Devon GP provider group, for funding for a single computer system to be used across these practices to help them work together. Access to shared patient records was to be via smart card by expressed patient consent. This was under the Prime Minister's Challenge Fund for innovative models of care for the benefit of patients across the area.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a form was used to record patient's consent, or that of the parent or guardian. It included the GPs confirmation that they explained the treatment, any options available and type of anaesthetic.

Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to

Good

Are services effective?

(for example, treatment is effective)

understood the key parts of the legislation and were able to describe how they implemented it in their practice where there were concerns about a patient's competence to give informed consent.

A GP who met patients with requests for contraception used their professional judgement about the competence of a patient under the age of 16 to make their own judgement in accordance with the Fraser guidelines, and had contact details of professional support for any query.

Health promotion and prevention

Television screens with customised health information were provided in the patient waiting rooms for example, about contraceptives, and back ache. Neat racks for leaflets were displayed in the different waiting areas. A member of the nursing team organised displays.

Members of the patient participation group told us they would be interested in helping present themed information in order to help signpost patients to services that would support them.

Nurses led on weight reduction programmes at the practice. There was a notice up in the waiting room about Barnstaple's diabetic club and nurses gave out information about diabetes to patients at their clinics. Nurses led smoking cessation sessions, individually or for groups. There had been a Quit Smoking group and gum and tablets had been dispensed.

The Information Centre for Health and Social Care provided statistics showing that this practice were better than average at providing patients who had physical and/or mental health with an offer of support and treatment within the preceding 15 months. A patient who had physical and mental health needs told us they were to join an enabling group and their GP would prescribe attendance at a gym.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The GP Patient Survey carried out by NHS England showed that the practice achieved slightly above average satisfaction scores on consultations with respect to respondents saying the GP and nurses were good at listening to them and gave them enough time, and treated them with care and concern. All GPs demonstrated a caring attitude. For example they had stayed on late to see a patient on a Friday evening when necessary.

We heard from 18 patients, through emails, telephone calls and meeting patients in the practice. Patients told us they had been pleased with the high standard of care from GPs, nurses and receptionists. Some said that other friends and neighbours had joined the practice and were all satisfied with their care and attention. Patients said they were not rushed during appointments, and GPs had provided the answers to their queries and referrals to other services had gone smoothly.

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 the ground floor treatment room had an exterior window with obscure glass but no curtain or blind so patients might feel exposed to people on the pavement outside.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Reception staff called patients over to the far end of the desk to give them results, away from the waiting area. If information was sensitive, they would invite patients into a private room.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Nurses and administration staff at the practice acted as chaperones as required. The chaperone policy was the focus of a training session with all staff recently. They understood their role was to reassure and observe that interactions between patients and doctors were appropriate.

Care planning and involvement in decisions about care and treatment

GPs told us that as part of their work to meet an enhanced service for the commissioning body, they had produced care plans for 2% of their patients. They had chosen patients who would benefit, and for whom the integrated care promoted by planning would help keep them from being admitted to hospital. This included patients with brittle asthma, diabetes, overall frailty. All patients who came to the asthma clinic had a care plan, and work was going on to monitor and improve such achievement for patients with diabetes. GPs aimed particularly at patients who were not already supported by district nurses, to achieve the greatest impact and improvement in care standards. They reported an increasing use of treatment escalation plans (TEP) forms and appropriate liaison with family members when a patient lacked capacity to make decisions about their own treatment.

Patients we spoke to 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 choice.

Patient/carer support to cope emotionally with care and treatment

Patients with complex problems said they had been shown understanding and kindness and the care, manner and treatment from GPs had been second to none and very reassuring. Patients specifically mentioned the compassion and humour of reception staff. The reception staff team had all worked at the practice for many years and knew the patients well. 98% of patients completing the GP patient survey had been happy with the reception staff. They were welcoming and tried to help.

A health care assistant was trained to carry out thorough assessments of carers' needs. They also signposted people to services that could help them. The health checks

Good

Are services caring?

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the needs of the practice population and had systems in place to maintain the level of service provided and address identified needs. GPs had engaged with other practices in the area to promote improvements to services and information sharing so that referrals to other services were efficient. Staff understood the nature of patients who felt at ease with the non-clinical appearance of the service, in a town centre house.

The practice had fully supported the development of the patient participation group. Starting in 2007, the group had provided coffee mornings with blood pressure tests to raise awareness of the group and raise money. They had bought the nappy changing platform provided in the downstairs toilet, televisions for the waiting rooms, and some testing equipment for the treatment rooms. Pulse oximeters had been provided by the group in every treatment room, for easy regular checking of the levels of oxygen in patients' blood and their pulse rate.

A manager within the practice had been co-ordinating the group, as they had not yet identified a chairperson. The current group were considering ways to extend the range of patients who belonged to the group. The members told us of ideas they had to support the practice and advance the activity of the group. For example, they were interested in providing themed information in the waiting rooms, to signpost patients to particular services for a time for example, heart disease, mental health, weight loss and to invite speakers on the theme to their meeting.

Access to the service

The practice was open from 8am to 6pm Monday to Friday, and booked GP appointments were available from 7:30am. Comprehensive information was available to patients about appointments on the practice website. The practice had tried triaging by phone but patients did not like it so another system was introduced. At the time of this visit, patients could book in advance and see their own named GP, which they liked. Half of all appointments were 'book on the day'. There was pressure on reception staff at 8:30am. The duty GP did telephone triage for 20 minutes and booked in appointments for those they considered needed them. All GPs had four telephone slots each day. All under-fives were seen on the day without prior assessment.

At 8am, 'on the day' slots were available but by 8:30am all the booked 'on the day' slots were full and some GPs considered that the system needed reassessment. However, the GP patient survey showed slightly higher than average percentage of patients were satisfied with phone access, with opening hours and their ability to see or speak to a GP or nurse and their overall experience.

Patients told us they had preferred GPs and said they would book weeks ahead to see them. They had found their GP explained everything, one patient commenting that the GP had explained well enough to their young sister so that she had understood the issues. They had been very pleased with this. Patients agreed they would see any GP in an emergency.

There was no patient parking though there were car parks nearby. Access to the ground floor was via a slight ramp from street level to ground floor, and a 'push pad' door opener. The reception desk, waiting room, two consulting rooms, one treatment room, and a toilet suitable for wheelchair users were all on the ground floor. A flight of stairs led to the rest of the premises. There were two consultation rooms on the first floor. One ground floor room was set aside for the use of patients who could not get upstairs.

In the waiting room there were little chairs and tables for children, with a puzzle. There were chairs with raised seats to help patients with reduced mobility and all the chairs had arms. The accessible toilet had room for wheelchair users and a simple effective lock. There was another ground floor toilet, which had a lock that was stiff to use.

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 policy was to acknowledge complaints within three days and complete in four weeks. We saw that GPs wrote detailed explanations in response to patients' concerns. An annual review of complaints had been introduced to help check for any areas of concern emerging. The appointments system had been raised as a complaint, because all the 'on the day' slots were taken up by 8.30am. Staff agreed to audit the system again. The team had been

Good

Are services responsive to people's needs?

(for example, to feedback?)

discussing the benefits of recording minor concerns and had agreed at a meeting in the week prior to this inspection to implement this, to enable a response to be made and recorded.

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 clear about its aim to be a caring GP practice, patient centred and responsive, to provide quality care and promote wellbeing. The partners were enthusiastic about the development of their practice, involving joint working with another GP practice and greater collaboration with practices and services across the area. A GP had met with the CCG and providers group about their vision.

The GP partner who was IT lead for the practice had made a successful bid on behalf of the North Devon GP provider group, with 23 member practices, for central funding to obtain a new computer system. This was outstanding practice as it would benefit other practices in North Devon as well as Boutport Medical Centre. The bid was for funding for a single computer system to be used across these practices to help them work together. Access to shared patient records was to be via smart card by expressed patient consent. This was under the Prime Minister's Challenge Fund for innovative models of care. Health care professionals recognised it was a quality issue for patients that GPs could access other practitioners' records as it helped them provide continuity of care. In addition, the practice was developing its intranet to save and share good practice and clinical information.

Options for new practice premises had been explored but there were no firm plans at this stage. Patients liked this building and staff told us the place of this practice was in the community as it was central to the town and patients felt comfortable about coming in. There were problems with the building due to being on three floors. The arrangement of rooms was precluding the practice from offering some extended services and hosting a registrar. The continuing consideration of plans was impacting on the service provided today as potential improvements to the current building were limited and staff were uncertain of the future.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. The senior partner was in the process of registering as manager with CQC following the departure of the previous registered manager. A GP took the lead role for prescribing and clinical governance. There was a lead nurse for infection control and a named GP was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards and above average with respect to support provided to some vulnerable groups.

Leadership, openness and transparency

All five GP partners worked part time. The senior partner proposed increasing the frequency of partners meetings and holding them weekly. The GPs had no dedicated management time despite the significant changes taking place within the practice, but recognised they needed to meet more frequently due to the need to make progress with planning.

Administrative staff had held meetings monthly. They were considering increasing the frequency of their meetings to support staff through the changes that were being introduced. A full time practice manager had recently left the practice, and a new practice manager had very recently started to work across two practices, promoting shared learning and collaborative practice. Other staff were rearranging working practice to help make this a workable arrangement. Administrative staff told us they had good lines of communication within their own team.

Communication was considered to be key at this time of change. Working relationships between GPs and staff were good, but not enough formal communication took place regularly, leaving staff anxious due to plans and essential changes to service provision. The new practice manager proposed that monthly meetings would be good for the whole team. Serious event analysis (SEA) meetings were to be quarterly and to be multi-disciplinary and nurses were to be invited to join the monthly complex care meeting.

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

On their website the practice reported back from the GP patient survey and promoted the Patient participation group (PPG). The latest report was available on the home page. Following discussion with the Patient Participation

Are services well-led?

Good

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

Group the practice decided to do away with the 'Emergency Queue' system for urgent appointments and trial a 'Duty Doctor' each day who triaged any urgent requests to be seen and if necessary invited the patient in to an appointment in the afternoon. At a subsequent PPG meeting, concerns about the lengthening time patients had to wait for a pre-bookable appointment were discussed, and it was agreed that further work was needed, to ascertain the reason for the appointments and to check whether the system could be further improved.

PPG members felt they were well supported by the practice, and that all staff at Boutport were hardworking, dedicated caring people who did everything they could for their patients. PPG suggestion slips were available in the waiting rooms.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and they knew who they would speak to about any suggestion or concern.

Management lead through learning and improvement

The constraints of the building precluded the practice becoming a training practice for GP registrars. Two partners would like to become trainers but no consultation room was available for a registrar. One GP took medical students from the university.

Nurses had good access to training courses. There had not yet been an evaluation with the nurses of what the practice needed, leading to directed development of skills and qualifications.

Training was provided for nurses as they requested. The practice had not identified its training needs in recognition of planned development.