Care Quality Commission

Clock Tower Surgery

Quality Report

Clock Tower Surgery
Wat Tyler House
King William Street
Exeter
Devon
EX4 6PD
Tel: 01392 208290
Website: www.devondoctors.co.uk/the-clocktower-surgery

Date of inspection visit: 10 May 2017
Date of publication: 29/06/2017

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Clock Tower Surgery on 10 May 2017. Overall the practice is rated as outstanding.

Clock Tower Surgery was established in March 2000 in response to a national and local health care agenda. It is a specific GP practice commissioned to provide access to NHS primary care services for approximately 570 homeless and vulnerably housed patients. The vision and aim of the practice was to move patients on to mainstream GP practices once they had stabilised their lives and housing.

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

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from serious significant events. Lessons were shared across the organisation and with other practices within the organisation.
- The practice had clearly defined and embedded local and organisational systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. GPs, nurses and locum GPs were skilled in caring for the patient group and had qualifications and experience in caring for patients with substance misuse, challenging behaviours and supporting patients who were homeless or vulnerably housed.
- One of the GPs working at the practice was a GPwSI (GP with a special interest) and prescribed medicines used in heroin, alcohol and opioid addictions. Between October 2016 and March 2017 83 patients were prescribed these medicines.
- Staff worked with the RISE service (Recovery and Integration Service) and hosted RISE six clinics per week at the practice allowing for closer communication between the RISE workers, practice staff and patients. The GPwSI was provided with clinical supervision from the RISE clinical lead.

Summary of findings

- There was a proactive approach to understanding the needs of this vulnerable patient group. Staff acted as advocates and delivered care in a way that meets patients' needs and promoted equality.
- Patients told us they were treated with dignity and respect and were involved in their care and decisions about their treatment.
- There was consistently positive feedback from the Friends and Family Test.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with the GP and said there was continuity of care, with drop in appointments and urgent appointments available the same day. An average of 300 patients per month had used the GP drop in service over the last three months (130 for the nurse) and 150 patients had attended booked appointments (45 for the nurse).
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by local and organisational management. There was an atmosphere of mutual respect and team work amongst the staff group.
- There were systems in place to monitor and improve quality, identify business risk and systems to manage emergencies.

We saw three areas of outstanding practice:

There was a truly holistic approach to assessing, planning and delivering care and treatment to patients who use services. Staff worked collaboratively with many other providers, both within the hub and externally, to ensure the vulnerable patient group was supported to receive coordinated care which met their needs. Practice staff used opportunistic, innovative and efficient ways to deliver more joined-up care to patients. For example, the practice worked with the Hepatology Department at theRoyal Devon and Exeter (RD&E) Hospitals NHS foundation Trust to provide an outreach drop-in clinic to see patients with viral hepatitis. Since December 2016 the hepatology nurse had completed 12 fibrosis scans (a simple and non-invasive test that can reveal any fibrosis or fatty deposits within the liver) at the practice meaning patients did not need to attend the RD&E hospital.

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met vulnerable patient's needs. The staff worked as advocates and used innovative approaches to providing integrated person-centred pathways of care that involved other service providers and charities both within the hub where the practice was situated and externally. The aim was to move patients onto mainstream GP services once patients had stabilised their housing and social situations in conjunction with their health needs. As a result, between October 2016 and March 2017 the practice had enabled 123 patients to move on to mainstream services.

Practice staff provided a GP service to patients who had been barred from other services due to the nature of their behaviour. The practice staff used an Acceptable Behaviour Contract where needed to ensure behavioural boundaries were agreed whilst they received treatment. Practice staff had shared this contract with NHS England and other GP practices and given advice when requested of how to manage difficult situations.

The areas where the provider should make improvement are:

Review processes, systems and records for lower level incidents and occurrences.

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.

- There was a system in place for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice and shared within the wider organisation and externally to stakeholders where appropriate. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again. Although records were kept these were not consistently held for lower level incidents and occurrences. For example, making sure the correct printer paper was available for the ECG (heart monitor) machine.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- There was a truly holistic approach to assessing, planning and delivering care and treatment to patients who use services through the wider engagement of a range of other health and social care professionals.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice. GPs had specialist skills and experience of caring for patients with substance misuse, homelessness and challenging behaviours.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked collaboratively with many other providers to ensure the vulnerable patient group was supported to receive coordinated care which met their needs. Practice staff used opportunistic, innovative and efficient ways to deliver more joined-up care to patients.
- The practice worked with the Hepatology Department at theRoyal Devon and Exeter Hospitals NHS foundation Trust to provide an outreach drop-in clinic to see patients with viral hepatitis.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the friends and family test results showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible within the same building.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- There was a proactive approach to understanding the needs of this vulnerable patient group. Staff acted as advocates and delivered care in a way that met patient needs and promoted equality.
- The practice took account of the needs and preferences of patients with vulnerabilities which included mental health issues, homelessness and substance misuse.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patient's needs. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers both within the hub and externally. For example, the practice was situated within a Health, Wellbeing and Community Hub used

Summary of findings

for patients within central Exeter presenting with complex needs. As a result, between October 2016 and March 2017 the practice had enabled 123 patients to move on to mainstream services.
- Patients we spoke with said they found it easy to make an appointment and said there was continuity of care, with urgent appointments available the same day. Patients could use the walk in clinic or be seen by appointment at different times of the day if they preferred. Over the last six months an average of 300 patients per month had used the GP walk in service (130 for the nurse) and 150 patients attended pre booked appointments (45 for the nurse).
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from examples reviewed showed the practice and organisation responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

Outstanding

- The practice management and organisational management shared a clear vision and adopted a passion and culture to deliver high quality care person centred care and promote good outcomes for patients. There was a strong collaboration and support across all staff within Access Health care and staff shared a common focus on improving quality of care and people's experiences.
- There was a clear leadership structure both within the organisation and at the practice. Staff felt supported by management. The practice had policies and procedures to govern activity and had provided guidance to other GP practices around the management of patients with similar issues.
- The practice and wider organisation held regular governance meetings to review quality and performance.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities specific to patient's needs.
- The provider was aware of the requirements of the duty of candour.

Summary of findings

- The organisation encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on to improve services for patients.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients. For example, substance misuse and mental health.

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

This population group was not rated because of the small numbers of patients in this population group.

- The practice had a small number of older patients. For example, of the 570 patients 66 were between the ages of 55 and 75 and four were above the age of 76. The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The GPs at the practice worked with staff in local nursing homes when patients lived there.
- The practice worked closely with community nursing staff to ensure effective outcomes for patients.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice followed up on older patients discharged from hospital and ensured that any extra social or health needs were addressed.
- Where older patients had complex needs, the practice shared summary care records with local care and support services.
- The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments as well as a walk in appointment service to see a GP and/or nurse every day.

People with long term conditions

This population group was not rated because of the small numbers of patients in this population group.

- The practice had found the most effective way of working with patients with long term conditions was by using ‘opportunistic’ screening and reviews and by also using a robust re-call system.
- The practice nurses had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- When patients attended the practice for the first time they had a named GP who with the support of the nurse carried out health screening checks. Patients were then offered an individualised plan, with structured reviews of their health and medicines whilst they remained registered at the practice.

- If practice staff were unable to contact a patient through recall, text reminder or a telephone call, one of the clinicians completed a welfare visit to the person's last known abode or made contact via other involved services.
- Patients were made aware of the wide range of support sources that were available to them. Social Services and Community Services were also contacted if required by the GPs and the patient.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional social or health needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Families, children and young people

This population group was not rated because of the small numbers of patients in this population group.

- The practice was available for the 'homeless and vulnerably housed' so did not encourage families or young children to register but were directed to other mainstream GP practices.
- If any female patient became pregnant practice staff linked them in and liaised closely with the duty midwife and maternity services.
- Pregnant patients were added to the practice 'complex patient' list for regular discussion at the fortnightly practice meetings. Once the baby was born they were seen by the nursing team for the initial vaccinations before being encouraged and supported to register in a main-stream practice.
- The practice had a very small number of young patients registered. Depending on their age and housing status these patients were treated as any other patient but offered additional support. For example, housing, benefits and food vouchers through a co-ordinated approach by the practice and other local agencies.
- The practice had a small number of young patients living at the local YMCA and worked with additional support workers for the care of those patients.
- Access to contraception advice and support was also available to young patients.

Working age people (including those recently retired and students)

This population group was not rated because of the small numbers of patients in this population group.

- The majority of the registered patients were of working age or older, due to their circumstances; however, being homeless or vulnerably housed, they were not able to work due to ill health, substance misuse and social situations.
- The practice offered five 15 minute 'walk in' appointments each morning and often added additional appointments for patients in need in response to fluctuating demand.
- The practice did not currently offer extended hours as patient demand did not require this.
- Students located within the city were re-directed to the University to seek advice on an appropriate practice.
- Practice staff acted as advocates and gave assistance to patients to help them access financial and housing support so they might take the first steps towards having a more stable life.

People whose circumstances may make them vulnerable

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

Outstanding

- The majority of patients at the practice were classed as 'vulnerable' either due to their social circumstances (housing situation), health or both. For example, homeless patients, travellers, patients with mental health issues and those with learning difficulties. The aim was to refer patients to a mainstream GP but this only happened when there was evidence that patients were ready and were permanently housed.
- The dedicated Clock Tower team acted as advocates for patients and worked in partnership with other involved services to ensure that vulnerable patients took priority and were monitored and sign-posted appropriately to receive the best care and support available.
- The practice was situated within the health and wellbeing community hub which made it easier to signpost directly and avoid unnecessary delays with care plans and duplication of work. This enabled all patients to receive the most effective care pathway for their circumstances.
- GPs working at the practice had experience in the treatment of substance misuse and took part in shared care prescribing for 70 patients who were part of the RISE service (Recovery and Integration Service). This enabled the GPs to engage and treat vulnerable and hard to reach patients with an aim to reduce drug- related deaths and improve both health and social care outcomes.
- Staff interviewed knew how to recognise signs of abuse in young patients and adults whose circumstances may make

them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

- Homeless patients could access a GP from the practice without an appointment at the walk in clinic five times a week. They could also be seen by appointment at different times of the day if they preferred. The practice was responsive and saw all patients needing urgent assessment and treatment within minutes of arriving.
- Staff from the practice had volunteered with the outreach team by providing hot drinks to homeless people in the streets of Exeter and used the opportunity to identify people in need of health care provision.
- The practice offered 15 minute appointments as standard.

People experiencing poor mental health (including people with dementia)

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

- The practice was situated within a Health, Wellbeing and Community Hub for patients within central Exeter presenting with complex needs. Services include: substance misuse, housing needs (homelessness), offending behaviours, access to primary health care services, access to employment and training, together with access to benefit and debt advice. This provided services under one roof for patients and promoted well co-ordinated care and support for them. Almost all patients attending the practice had received assistance from one or more of these services in conjunction with the practice.
- Staff knew their patients well enough and had received training and mentorship to detect early signs of mental health relapse and worked closely with patients to keep them safe.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.
- The mental health team were sited within the surgery at Wat Tyler House.
- The clinical team liaised as required with the mental health team and also met every Wednesday morning with the team and psychiatrist to discuss and review the current caseloads, priorities and update the patient plan on the clinical system.
- Safeguards were in place to make sure high risk medicines were identified and regularly monitored. The practice held a list of all patients on ‘depot’ medicines (), which included the date when

Outstanding

Summary of findings

it was last given and next one due. The list was closely monitored by the practice nurse and demonstrated the team was proactive in engaging with patients on this medicine to ensure their safety.

- Records showed medicines were given as prescribed, which was crucial in stabilising patient’s mental wellbeing so they did not experience unnecessary hospital admission due to mental health crisis. Patients had experienced a discussion about their lifestyle, about their drinking, smoking habits and use of legal highs to help them understand the risks involved with their lifestyle.
- The practice carried out cervical screening for female patients. Of the 64 eligible patients (25 years plus), 38 smears had been completed (60%) within last 5 years, 11 within the past 12 months. The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations; this was actively promoted by practice staff.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Shared premises enabled face to face discussions to take place and for responsive support to be available when patients were in crisis.
- Staff had received training on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

Because the practice had been re-registered under new ownership there were no results from the national GP patient survey. However, the practice had carried out their own survey intermittently with the friends and family test. We looked at 26 forms from the Friends and Family Test, collected over the last four months. Of these 22 were extremely likely or likely recommend the practice to their friends and family, two were extremely unlikely or unlikely and two had a neutral response.

Between October 2016 and March 2017 the practice had collected 102 internal survey results. Of these 83 thought the service was excellent or very good, 10 acceptable, four poor and five very poor.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 comment cards which were all positive about the standard of care received. Comments on these cards included satisfaction of the service provided.

Patients said they found staff friendly, excellent and understanding and stated that care and treatment was great, excellent, efficient and brilliant. There were no negative comments. Comment cards also contained positive feedback about individual members of staff.

We spoke with 10 patients during the inspection. All 10 patients said they were satisfied with the care and treatment they received and thought staff were approachable, committed and caring. Patients added that staff treated them with respect and appreciated that they could access many services under one roof. Patients said obtaining routine repeat prescriptions was a straight forward process and said getting an appointment was generally good, although they often had to wait to be seen during the morning drop in appointments due to the complex needs of other patients, which they recognised.

Areas for improvement

Action the service SHOULD take to improve
Review processes, systems and records for lower level incidents and occurrences.

Outstanding practice

We saw three areas of outstanding practice:

There was a truly holistic approach to assessing, planning and delivering care and treatment to patients who use services. Staff worked collaboratively with many other providers, both within the hub and externally, to ensure the vulnerable patient group was supported to receive coordinated care which met their needs. Practice staff used opportunistic, innovative and efficient ways to deliver more joined-up care to patients. For example, the practice worked with the Hepatology Department at the Royal Devon and Exeter (RD&E) Hospitals NHS foundation Trust to provide an outreach drop-in clinic to see patients with viral hepatitis. Since December 2016 the hepatology nurse had completed 12 fibrosis scans (a simple and non-invasive test that can reveal any fibrosis or fatty deposits within the liver) at the practice meaning patients did not need to attend the RD&E hospital.

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met vulnerable patient's needs. The staff worked as advocates and used innovative approaches to providing integrated person-centred pathways of care that involved other service providers and charities both within the hub where the practice was situated and externally. The aim was to move patients onto mainstream GP services once patients had

stabilised their housing and social situations in conjunction with their health needs. As a result, between October 2016 and March 2017 the practice had enabled 123 patients to move on to mainstream services.

Practice staff provided a GP service to patients who had been barred from other services due to the nature of their behaviour. The practice staff used an Acceptable Behaviour Contract where needed to ensure behavioural boundaries were agreed whilst they received treatment. Practice staff had shared this contract with NHS England and other GP practices and given advice when requested of how to manage difficult situations.

Clock Tower Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and an assistant Inspector.

Background to Clock Tower Surgery

Clock Tower Surgery was established in March 2000 in response to a national and local health care agenda. The contract provided is an Alternative Provider Medical Services (APMS) contract. Clock Tower Surgery is managed by Access Health Care Ltd, part of the wider Devon Doctors group (a social enterprise organisation). It is a GP practice commissioned to provide access to NHS primary care services for approximately 570 homeless and vulnerably housed patients. The vision and aim of the practice was to move patients on to mainstream GP practices once they had stabilised their lives and housing.

There was no practice profile data available regarding the demographics of the practice.

The practice is situated in the city of Exeter and works closely with other mainstream GP practices, health and social care services. The practice moved to the current cross sector hub in April 2016. The practice staff work with and refer to the other services within the hub. These include a homeless outreach team, mental health services, housing support groups, benefit and debt advice, sexual health support organisations, alcohol and drug recovery services and offender management services.

Patients are able to access midwifery, physiotherapy and optician services at the practice.

The practice has two salaried GPs, one of which is female and one is male. The GPs work 10 sessions (one whole time equivalent) and are supported by two practice nurses who cover the week between them. The clinical team are supported by a practice manager, a receptionist and an administrator.

The practice was not a teaching or training practice but accommodated GP trainees to come and observe the assessment and treatment of patients as part of their wider training programme. The practice takes first and third year medical students on a regular basis throughout the academic year for the Peninsula Medical School (PMS). All of the students spend time shadowing the GP's and nurses and often have some project work in relation to the patient group. Complimentary feedback about the practice and the mentorship of the medical team from both the PMS and the students is often received. Clock Tower Surgery also supported the RD&E Hepatology department Exeter in accommodating some of their second year students.

The practice is contracted to open between 9.15am to 5pm with appointments available from 9.15am until 12.15pm and between 2pm until 5pm. Patients are able to access a drop in clinic between 9.15am and 10.45 all patients arriving at the practice during these times are seen.

Patients are encouraged to access the local walk in centre and out of hours service when the practice is not open.

The practice is registered to provide regulated activities which include:

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

Exeter Co Lab (Previously called Wat Tyler House)

Detailed findings

King William Street

Exeter

EX4 6PD

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 May 2017 During our visit we:

- Spoke with a range of staff including GPs, nurses, administrators, practice managers and reception staff. We also spoke with 10 patients who used the service and a support worker accompanying a patient.
- We observed a multidisciplinary mental health team meeting.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The management of significant event process was managed centrally at the Access Healthcare headquarters. The governance team followed a standardised process. Any event came to the team for classification into significant or serious events and incidents. Not all staff were aware of the threshold of these classifications. Although we were able to review records, meeting minutes and the data base, the level of documentation for some lower level events were not maintained fully at headquarters and did not provide opportunities to clearly audit the process followed and action taken. We looked at one significant event and staff were able to produce minutes of meetings and records to show the discussion that had taken place. We looked at one serious incident report held on the data base within Access Healthcare. This showed that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Serious incidents were reported externally to the CCG, NHS England and coroner where appropriate. Clinical decisions were discussed externally by a peer group and appropriate actions taken.
- We saw evidence that lessons had been shared and action taken to improve safety in the practice. For example, during an incident where a patient required their heart rate to be monitored; it had been highlighted that the wrong size paper had been ordered for the ECG (heart monitor). The patient came to no harm as a visual display was used by clinicians until ambulance staff arrived. A change of process included adding the ECG on the weekly emergency equipment checklist to ensure adequate paper supplies were held in the practice.
- Systems were in place to ensure learning and actions were shared with all staff. This was done within staff meetings, by email and included within weekly and monthly newsletters all of which we saw during the inspection.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Patients subject to safeguarding issues were added to the practice complex patient list and discussed at the multidisciplinary team meetings so that patients could receive appropriate support.

- We were given examples to demonstrate staff understood their responsibilities regarding safeguarding and how to escalate child and adult safeguarding concerns locally. All staff spoken with had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses to level two.

- Chaperones were used at the practice and were requested by both staff and patients. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with patients who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. These were monitored through checklists completed by staff. Monthly checks were carried out by

- the nursing team and annual infection control audits were also completed. The last audit had taken place in July 2016 and had resulted in additional cleaning, replacing the spillage kits and providing a new sink within the optician's room.
- One of the nurses was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date online training and annual handwashing training.

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

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, a recent review of antibiotic use confirmed the practice was in the top 20% of prescribers. However, a review of this confirmed there was an appropriate higher use of antibiotics because of the infections associated with drug abuse related infections, malnutrition, dental infections and other infections associated with homelessness and poor health and nutrition. Ongoing monitoring of antibiotic prescribing was undertaken to ensure it continued to be appropriate to the needs of patients.
- A recent review had improved the records kept regarding the distribution of blank prescriptions to the GPs. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed eight personnel files for the five practices within the Access Health Care organisation. Two of these were for staff at Clock Tower Surgery. We found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment performed in May 2017 and carried out regular fire drills. The last one being earlier in the month. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All portable electrical equipment had been tested in January 2017 and clinical equipment had been checked and calibrated to ensure it was safe to use and was in good working order. This had last been done in August 2016.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The risk assessment had been performed in May 2016 with weekly and quarterly water checks in place.

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice used a small number of GPs, nurses and locum GPs who were experienced in supporting the patient group. For example, working with the prison service and patients with substance misuse. This ensured continuity of patient treatment and knowledgeable management of patients' needs.

Arrangements to deal with emergencies and major incidents

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

- There were panic buttons in the reception area and systems for the staff elsewhere in the hub to alert Clock

Good

Are services safe?

Tower staff to escalating patient behaviours. There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

- The practice had access to security staff when required and had systems in place to deal with violent patients.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Systems were in place to ensure all the medicines were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Nursing staff held lead responsibilities for designated long term conditions but were able to provide care for all long term conditions. Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff were also using Gold respiratory guidelines for primary care and had used these to adapt templates used on the computer system.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

The GPs and nurses held lead roles in areas including sexual health, emergency medicine, diabetes, heart disease and asthma. Each GP had undertaken additional qualifications; for example, GP's had specialist qualifications in the care and treatment of substance misuse. The practice nurses had undertaken additional training in chronic disease, including asthma and diabetic management. This enabled the practice to provide opportunistic screening for patients, which took account of their transient lifestyle. For example, the practice staff had managed to perform 34 opportunistic blood screening tests between October 2016 and March 2017 resulting in more effective diagnosis and treatment for those patients.

GPs and the practice nurse were skilled in engaging patients. Whenever they had contact with a patient, staff explained they tailored this to what the patient needed and helped to develop a rapport with them so that further health screening and treatment could be encouraged and provided.

Management, monitoring and improving outcomes for people

The practice collected the information collected for the Quality and Outcomes Framework (QOF) internally as a measuring tool to monitor outcomes for patients but were unable to accurately compare their performance with other GP practices because the proportionally small and changing patient list often meant patients did not present with the relevant clinical indicators. The practice regularly discussed QOF data and practice progress at fortnightly practice meetings. Each of the clinicians managed their individual areas of responsibility. Data collected by the practice showed a growth in points achieved in the last six month period. For example, in October 2016 the practice had achieved 132.7 of the 545 points. In January this figure had increased to 184 and in March 2017 it had increased to 286 points.

The practice provided key performance indicators and a commissioner's progress report every six months. We looked at the last report and saw there were no areas of concern. The report showed that:

- Opportunistic blood borne screening was performed. In the last six months ten patients had been screened for hepatitis B and 11 patients screened for hepatitis C. Thirteen patients had been screened for HIV resulting in more effective diagnosis and treatment for those patients.

- The percentage of smokers who had been offered smoking cessation advice showed year on year improvements within QOF targets. For example, in October 2016 41% of patients had been offered advice. My March 2017 this figure had increased to 82%.
- The practice were not an outlier for; A&E Attendances, Emergency admissions, three or more Emergency Admissions, Emergency Admissions into Mental Health Secondary Care Services or secondary referrals.
- Despite stable patient population numbers the total number of patients moving to mainstream practice had increased from an average of 18 in October 2016 to 23 in March 2017.

There was evidence of quality improvement including clinical audit:

- We looked at five clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken as a result included an audit by one of the nurses to benchmark the current clinical practice regarding care of patients with leg ulcers in the surgery against current evidence based practice management. The audit found from the 14

patients who had a leg ulcer; all 14 patients were receiving the most current evidence based care. The action points included a planned re audit and development of the leg ulcer protocol to ensure it reflected any updated evidence based practice guidelines.
- Another audit looked at patients on psychoactive medicines (Benzodiazepine). The audit had been repeated regularly since 2013. The audit looked to ensure the use of the medicine was appropriate and monitored effectively. Data showed the number of patients on this medicine had fallen from 27 in July 2013 to 23 in November 2016 and an increase in medicine reviews performed. For example, in July 2013 21/27 (78%) had received a review and in November 2016 this had increased to 83%.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions and for staff managing drug overdoses. We also saw examples where specific training relating to individual patient need was provided which enabled patients to receive specialist care at the practice rather than travelling to the local acute trust. GPs, nurses and locum GPs were skilled in caring for the patient group and had qualifications and experience in caring for patients with substance misuse, challenging behaviours and homelessness.
- Staff administering vaccines had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff told us this process was supportive and tailor made to their role. We saw there was an induction pack for locum GPs. This contained information on emergency processes, useful telephone numbers, common policies, prescribing guidance and instructions for the computer systems. This pack was given to locum staff and signed by them to demonstrate it had been provided and they had read the contents.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support from the medical director within the organisation, one-to-one meetings and clinical supervision. Nursing and medical staff had access to support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

There was a truly holistic approach to assessing, planning and delivering care and treatment to patients who used services. Staff worked collaboratively with many other providers to ensure the vulnerable patient group was supported to receive coordinated care which met their needs. Approximately 18 patients had been regular reviewed and monitored from the complex patient's list between the period of October 2016 - March 2017. These included patients with pregnancy, cancer diagnosis, learning disabilities, substance misuse and safeguarding.

Practice staff used opportunistic, innovative and efficient ways to deliver more joined-up care to patients. Examples included hosting and working with staff from substance misuse clinics, liaising, communicating and working with the local walk in centres, sexual health clinics, local homelessness charities and out of hours providers. This was done with patient consent which was obtained from the external providers and the practice.

The practice identified patients who may be in need of extra support and signposted them to relevant services. This close working with other community services was evident. For example, housing outreach groups,

Good

Are services effective?

(for example, treatment is effective)

community mental health team, housing groups, opticians, housing, debt and benefit advisors were all situated in the same building and had daily face to face contact with staff at the practice about patients. We spoke with a member of staff from one of these agencies who said practice staff were caring, passionate and committed to access additional support for patients who were vulnerable.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including custodial services and when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals as needed.

Practice staff also worked with external groups and charities to ensure patients could access support. For example, the local walk in centre, out of hours provider, half way houses, a local homeless charity, housing support groups, benefit and debt advice and a multidisciplinary group ICE (Integrated Care Exeter).

The information needed to plan and deliver care and treatment was shared with these groups following consent from the patients. From observation, discussion with patients and the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. For example, sharing special notes of patents on alcohol detox programmes with out of hours providers.

Staff were available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for young patients, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was recorded using templates and free text within the computer patient record. We saw examples of written consent obtained for joint injection procedures and for immunisations and vaccines.

Supporting patients to live healthier lives

Staff told us health promotion was generally provided opportunistically and sometimes, due to the transient nature of patient's lives, meant that other health issues initially needed to be prioritised for treatment over promoting changes to lifestyle.

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were immediately followed up. We noted a culture amongst the GPs and nurses to use their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers once a trusting relationship had been developed with them.

The practice carried out cervical screening for female patients. Detailed data provided by the practice showed that cervical screening for female patients (with complex mental health needs) was well above the target set by the CCG. For example, in March 2017 all but seven of the patients had been screened.

Health promotion boards were used in patient waiting areas and had recently included education on issues including sexual health, liver disease, flu, mental health and alcohol use.

Good

Are services caring?

Our findings

There was a culture amongst the practice staff to deliver a kind respectful service. Relationships between patients and staff were caring and supportive. These attitudes were appreciated by patients.

Kindness, dignity, respect and compassion

All 10 patients told us staff at the practice were kind. The 27 comment cards also contained positive remarks about the kind, caring, friendly and supportive staff group. Individual staff were also praised. Patients told us staff treated them with respect. One patient told us that staff treated them as a person first and their homelessness did not affect the way they were treated.

The practice had carried out their own survey intermittently with the friends and family test. We looked at the results of these which showed patients thought the service was excellent or very good.

We spoke with two external healthcare professionals during our visit. They told us that staff treated patients with respect and empower patients to access the care and support they need.

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

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

We looked at 26 forms from the Friends and Family Test, collected over the last four months. Of these 22 were extremely likely or likely recommend the Practice to their friends and family, two were extremely unlikely or unlikely and two had a neutral response.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them although this sometimes made the wait time longer due to the needs of patients before them. Patient feedback from the comment cards we received was also positive and aligned with these views.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room signposted patients to a number of support groups and organisations in addition to those available in the hub. The practice's computer system provided a facility for GPs to record if a patient was also a carer however the majority of patients registered at the practice were not in contact with their family. Staff recognised this put patients at risk of social isolation and supported those patients to access additional support from other agencies. This included working with key workers who attended some appointments with their assigned patients if they were not engaging and may not turn up to appointments. We spoke with one key worker who said practice staff empowered patients to have a voice and made sure individual preferences and needs were listened to.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice was commissioned to provide access to NHS primary care services for approximately 570 homeless and vulnerably housed patients.

Between October 2016 and March 2017 Clock Tower Surgery GPs had seen 1694 patients attend the walk in appointments and 914 attend routine appointments. Clock Tower Surgery nurses had seen 791 patients in walk in appointments and 268 in routine appointments. The GPs and nurses had also provided an additional 1000 telephone consultations between this period.

- Homeless patients could access a GP from the practice without an appointment at the walk in clinic five times a week. They could also be seen by appointment at different times of the day if they preferred. The practice was responsive and saw all patients needing urgent assessment and treatment within minutes of arriving.
- The practice offered 15 minute appointments as standard.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- GPs working at the practice had experience in the treatment of substance misuse and took part in shared care prescribing for 70 patients who were part of the RISE service (Recovery and Integration Service). This enabled the GPs to engage and treat vulnerable and hard to reach patients with an aim to reduce drug-related deaths and improve both health and social care outcomes. Patients had access to this service six times a week. Between October 2016 and March 2017 128 patients had accessed this service. The service enabled the GPs to engage and treat vulnerable and hard to reach patients with an aim to reduce drug- related deaths and improve both health and social care outcomes.
- The Clock Tower Surgery had started using dried blood-spot testing for Blood-Borne Viruses (BBVs) with the kits being supplied by RISE. This allowed patients with poor venous access (common in IV drug users) or fear of needles greater access to testing.

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patient's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers both within the hub and externally with an ultimate aim to move patients on to mainstream GP services but only once they had stabilised their lives. For example:

- The practice was situated within a Health, Wellbeing and Community Hub used for patients within central Exeter presenting with complex needs. Practice staff worked with these services which included drug and alcohol dependency, housing needs (homelessness), offending behaviours, access to primary health care services, access to employment and training, together with access to benefit and debt advice. This provided services under one roof for patients and promoted well co-ordinated care and support for them.
- We saw and heard of examples where patients had attended the practice for an appointment and then were supported by staff to access additional support including clothing, food vouchers and advice on housing and financial matters. This helped raise patients self-esteem, ensure a basic diet was accessible and help begin to stabilise their lives. As a result of joint working, between October 2016 and March 2017 the practice had enabled 123 patients to move on to mainstream services and improved lifestyles.

Practice staff had recognised that patients experienced limited access to ophthalmology services and had responded by providing practice space and facilitating an opticians service which was staffed by volunteer opticians.

The practice worked with the Hepatology Department at theRoyal Devon and Exeter Hospitals NHS foundation Trust to provide an outreach drop-in clinic to see patients with viral hepatitis. The clinic was set up to see patients with viral hepatitis who had previously not attended their appointments(DNA) at the RD&E. The clinic now saw patients with viral hepatitis and those with anyliver disease either through booked appointments or as a drop-in

appointment. This had been successful in reducing the DNA rate in medical outpatients at the RD&E and had been successful in engaging vulnerable patients into treatment programmes who had previously never accessed care. Patients were offered vascular access and Fibroscans (a simple and non-invasive test that can reveal any fibrosis or fatty deposits within the liver). Between October 2016 and March 2017 34 patients had accessed this service. Since December 2016 the hepatology nurse had completed 12 scans resulting in improved treatment plans for these patients.

The lead GP at the practice had instigated a weekly multidisciplinary team meeting with the mental health team including community psychiatric nurses, liaison psychiatrist and case worker. These meetings were opportunities to discuss individual patient needs and review the current caseloads, priorities and update the patient plan on the clinical system. Practice staff then responded to each patient needs. We also saw the mental health teams used this time to meet patients opportunistically to discuss their mental health needs.

Practice staff provided a GP service to patients who had been barred from other services due to violence. The practice staff used an Acceptable Behaviour Contract where needed. Practice staff had shared this contract with NHS England and other GP practices and given advice when requested of how to manage difficult situations.

Access to the service

The practice was open between 9.15am to 5pm with appointments available from 9.15am until 12.15pm and between 2pm until 5pm. Patients were able to access a drop in clinic between 9.15am and 10.45 all patients arriving at the practice during these times were seen. Extended hours appointments were not offered at the practice as patient demand had not required this.

Patients told us on the day of the inspection that they were able to get appointments when they needed them and appreciated the 'drop in' appointments.

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

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated team within the governance department at the organisations headquarters who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, information was found on the website, within the patient leaflet and within the practice waiting area.

None of the ten patients we spoke with had made a complaint. All said they would speak with the receptionist, practice manager, nurse or GP if they were unhappy with the service.

We looked at five complaints received in the last 12 months from the Access Health Care group. All complaints had been managed centrally at the Access Health Care headquarters. All had been dealt with in a timely way, with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, at The Clock Tower a complaint had been received about medicines prescribed. This had been investigated by a doctor within the organisation to ensure clinical care and treatment had been appropriate. The patient had received an explanation of the investigation findings and learning was shared across the group.

Are services well-led?

Outstanding

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

Our findings

Vision and strategy

The practice management and organisational management (Access Healthcare Ltd) shared a clear vision and had adopted a passion and nurtured a culture to deliver high quality care person centred care and promote good outcomes for patients who faced major health and social challenges. There was a strong collaboration and support across all staff within Access Health care and staff shared a common focus on improving quality of care and people's experiences.

The practice team were supported by the Access Health Care organisation to work with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

Staff within the practice had a shared purpose to deliver and motivate their vulnerable patient group to succeed. Patients told us the staff group were respectful and encouraging.

The leadership within the practice saw the involvement of other organisations and the local community as integral to how services were planned. As a result this joint working enabled patients to move on to mainstream GP services and improved lifestyles.

Governance arrangements

The practice and organisation had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. One of the GPs working at the practice was a GPwSI (GP with a special interest) and prescribed medicines used in heroin, alcohol and opioid addictions. Between October 2016 and March 2017 83 patients were prescribed these medicines. All staff acted as advocates for their patients and ensured they were able to access the services needed. Governance arrangements were in place to ensure prescribing was appropriate and in line with national guidance.
- Staff worked with the RISE service (Recovery and Integration Service) and hosted RISE six clinics each week at the practice allowing for closer communication between the RISE workers, practice staff and patients. Governance arrangements ensured the GPwSI was provided with clinical supervision from the RISE clinical lead.
- Practice specific policies were implemented and were available to all staff. Governance arrangements ensured these were updated and reviewed regularly. We learnt of examples where practice staff had supported NHS England staff and GP practices in the management of challenging behaviours and use of Acceptable Behaviour Contracts.
- There was a small but effective team of staff who met informally daily and more formally each week to discuss the practice, planned appointments and any occurrences affecting their patients. Practice meetings provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor and demonstrate quality and to make improvements to the care provided.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

There were high levels of staff satisfaction. Staff were passionate about the service and proud of the organisation as a place to work and speak highly of the culture. There were consistently high levels of constructive staff engagement at local and organisational level. Staff at all levels were actively encouraged to raise concerns and offer feedback.

Staff explained that the organisation provided clear leadership and were accessible when needed but gave support for the practice staff to provide the service. On the day of inspection the practice leadership demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us they prioritised safe, high quality and compassionate care and told us the GPs and practice manager were approachable and always took the time to listen to all members of staff.

Are services well-led?

Outstanding

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

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The organisation encouraged a culture of openness and honesty. For example, complaints documents demonstrated that the practice had systems to ensure that when things went wrong with care and treatment. For example, the practice gave affected patients reasonable support, truthful information and a verbal and written apology.

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

- The practice held informal and minuted weekly multi-disciplinary meetings including meetings with the complex care team to monitor vulnerable patients. Approximately 18 patients with a pregnancy, cancer diagnosis, learning disabilities, substance misuse and safeguarding had been regularly reviewed between October 2016 and March 2017.
- We saw examples where staff demonstrated a mutual sense of respect between their patients, other healthcare professionals and each other.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported by the organisational management and management in the practice. All staff were involved in discussions about how to run and develop the practice, and the organisation encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. Staff explained that obtaining written feedback was particularly difficult and setting up patient groups had proved difficult because of the transient nature of the patient group and reluctance for previous patients to return to the practice once they had stabilised their lifestyles.

- We looked at 26 forms from the Friends and Family Test, collected over the last four months. Of these 22 were extremely likely or likely recommend the Practice to their friends and family, two were extremely unlikely or unlikely and two had a neutral response.
- Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, practice staff had shared the acceptable behavioural contract with NHS England and other GP practices and given advice when requested of how to manage difficult situations.

Practice staff used innovative and efficient ways to deliver more joined-up care for patients. For example, the practice worked with the Hepatology Department at theRoyal Devon and Exeter (RD&E) Hospitals NHS foundation Trust to provide an outreach drop-in clinic to see patients with viral hepatitis meaning patients could be treated in more familiar surroundings and more likely to access screening.

GPs working at the practice took part in shared care prescribing for patients who were part of the RISE service (Recovery and Integration Service). As part of this joint working the practice had promoted the use of dried blood-spot testing for Blood-Borne Viruses (BBVs) which allowed patients with poor venous access (common in IV drug users) or fear of needles greater access to testing.