Cheriton Bishop & Teign Valley Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cheriton Bishop & Teign Valley Practice on 15 July 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing responsive and caring services. It was good for being safe, effective and well led. It was outstanding for all six population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their treatment. Information was provided to help patients understand the care available to them.
- Patients' needs were assessed and care was planned and delivered following current guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice worked closely with other organisations, charities and with the local community in planning how services were provided, to ensure that they meet patient need.
- The practice had implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as the top priorities. A business plan was in place, this was monitored regularly and reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Summary of findings

We saw several areas of outstanding practice including:

Unannounced role play training had been additionally provided for staff to practice and review their response and skills when dealing with emergencies.

The practice reached out to the community and supported and worked in partnership with a local charitable community support service (ACORN). The practice offered office space and resources to this charity who provided transport and prescription delivery in a rural area and offered services such as lunch clubs, coffee mornings and trips to the supermarket which reduced social isolation. The practice invited the coordinator of Acorn to the monthly multidisciplinary team meetings where the pastoral care, equipment provision and monitoring of vulnerable patients was coordinated.

The practice was exceptionally caring. Patients said that staff went the extra mile and the care they received exceeded their expectations, this was in line with the practice track record of consistently being above national average data scores for patient care and treatment. Patients repeatedly referred to the service as being caring, respectful, exceptional, efficient and outstanding and shared many examples which supported that staff had gone above and beyond what was expected.

Patients described the practice as being very responsive to their needs. Services were tailored to meet the needs of patients and were delivered in a way to ensure flexibility, choice and continuity of care. This responsive service had resulted in excellent survey results and significantly lower Accident and Emergency attendance rates.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Lessons were learned and communicated widely to support improvement.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines, which they used routinely. Data showed patient outcomes were equal to, or above, average for the locality.

Patient needs were assessed and care was planned and delivered in line with current legislation. This included assessing patient capacity to make decisions about their care and treatment and promoting good health. Information for vulnerable or at risk patients was shared with other health care professionals effectively.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams which promoted integrated care for patients.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive.

Summary of findings

We found many positive examples to demonstrate how staff had gone 'above and beyond' to meet patients' needs and those of their family. Patient choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

The practice had initiated positive service improvements for patients that were over and above contractual obligations. This included fundraising for the local support charity and visiting end of life patients at weekends to provide reassurance and continuity of care.

Suggestions for improvements had changed the way services were delivered. The practice reviewed the needs of the local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure service improvements.

Access was particularly good at the practice and feedback about appointments had been consistently good over a number of years. Patients told us it was easy to get an appointment with a GP of choice. Patients could request home visits and GPs often visited or contacted patients without being prompted.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good ●

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

There was a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure, which was non-hierarchical, and staff felt supported by the practice manager and GP partners. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and had promoted improvement.

Summary of findings

Staff had received inductions, regular performance reviews and attended staff meetings and events.	

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients.

Patients were allocated a named GP upon registration but were able to choose whom they felt most comfortable as their usual GP. The practice fostered an ethos of continuity of care and as such encouraged patients to see their usual GP. There was a practice policy for patients to be seen or spoken to on the day, if possible, with their usual GP.

There was a register of vulnerable older patients who were at risk of admission to hospital. This was populated by internal practice discussion and use of a risk stratification tool. If older patients were at risk of admission, they had a care plan of on-going wishes and care needs. Patients then consented to relevant information being added to the software system, so GPs they saw out of hours (OOH)could provide continuity of care. There was a monthly multi-disciplinary team (MDT) meeting to discuss older patients most at risk, such as those with on-going problems or who had been admitted or discharged from hospital. Patients who had been in hospital were highlighted for an early GP review. The local care home said the GPs visited any patient who had been discharged from hospital without prompting.

The practice worked with the local hospice. Patients in need of palliative care had care plans and were discussed at MDT meetings. These care plans were also added to the OOH system, which promoted continuity of care. The practice aimed to care for patients at home where possible and worked with the primary health care team to achieve this. The GPs sometimes visited end of life patients at weekends to offer continuity of care and reassurance.

All older patients on regular medication had an annual review of their health including a dementia screen. This was prompted by their medication review date and followed up by the dispensary team too. The dispensary team alerted the GPs to patients who were over-due a review. Other patients were picked up opportunistically if they attended the practice.

The practice worked proactively with Acorn, a charitable local community support service. The practice invited the coordinator of Acorn to monthly MDT meetings where the pastoral care, equipment provision and monitoring of vulnerable older patients was

Summary of findings

coordinated. The result of this integration provided older patients with social support, reduced isolation, and offered transportation of patients to both medical and social appointments thus promoting their health and well being. Geographically isolated older patients could have their prescriptions delivered.

The local care home had been given a named GP for all patients to aid continuity. The care home were very complimentary about the prompt, caring and respectful service the practice provided.

The practice used specific templates for older person health checks that prompted a falls assessment, dementia screen, carer details and offered carers wellbeing/health checks.

People with long term conditions

Outstanding ☆

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

The practice ensured annual checks, follow ups and reviews were offered at a time of the patient's choice. The nurses ran chronic obstructive pulmonary disease (COPD), asthma, diabetes, and leg ulcer clinics and had equipment to assist with diagnosis and monitoring, such as spirometers and doppler machines.

There were also recall systems for chronic disease and treatment monitoring investigations such as arthritis and long-term mental health. Patients prescribed medicines for long term conditions had regular medicine reviews to ensure they were receiving a therapeutic dose. The dispensary team flagged up any overdue medicine reviews to the GPs so that none were missed. The dispensary team also monitored for any over or under use of medicines which would then be communicated to the GPs.

Patients with long term conditions were always reviewed following discharge from hospital. This was undertaken by the usual GP either by phone or visit. Appropriate information was uploaded to the OOH computer system.

The practice actively promoted health education about long term conditions and encouraged self-help; they performed well in all vaccination schemes.

The practice maintained an up to date carers' register, invited carers annually for a health check and linked them to the practice carer support worker.

Families, children and young people

Outstanding ☆

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

Summary of findings

Antenatal clinics were held in the practice and the GPs worked closely with the midwives. There was good communication with midwife and health visitor during the antenatal and postnatal period.

There were alerts and systems in place for the patient's GP to contact or visit in the immediate post-natal period.

There was a health visitor based at the practice; this meant that there was effective communication with the health visitor regarding children and families with on-going problems. The health visitor was involved with children of all ages and not just those under five years old.

There was an effective recall system and follow up regarding childhood immunisations and catch up immunisations. Immunisation rates had been consistently good over the last two years.

Young patients were actively and sensitively encouraged to partake in chlamydia screening, with information available in the treatment rooms and on the website.

The practice had improved access to this group with the on-line booking and prescription service.

Safeguarding systems were in place and discussion at clinical meetings for on-going problems occurred monthly and whenever required.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people.

The practice population group included a large group of patients who work or attend schools and colleges. There was also a retirement complex of mobile homes in a nearby village.

The practice offered a walk in clinic from 8am Monday to Friday and also late nights 6.30 - 8.pm on Tuesday evenings.

Patients were also able to contact the practice by e mail to gain advice regarding minor issues. The practice actively promoted health checks opportunistically in this age group.

Access to prescriptions was either arranged at the practice or a pharmacy of the patient's choice. Systems were in place to enable prescriptions to be picked up out of standard practice hours at a number of other locations.

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Summary of findings

People whose circumstances may make them vulnerable

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Access to prescriptions was either arranged at the practice or a pharmacy of the patient's choice. Systems were in place to enable prescriptions to be picked up out of standard practice hours at a number of other locations.

People experiencing poor mental health (including people with dementia)

Outstanding

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

The practice told us they had a relatively low prevalence of patients with severe mental illness. The GPs had a good working relationship with the local psychiatrist, had access to rapid telephone support and had a detailed mental well-being resource directory, so staff could easily access relevant services. The practice staff also worked with and referred patients to other agencies, such as alcohol services and mental health crisis teams, and encouraged use of the practice for appointments as required. The GPs ensured continuity of support for this patient group with an active recall system to ensure both mental and physical monitoring and reviews occurred regularly.

The practice worked with an allocated depression and anxiety service worker who visited the practice each week to provide any intervention needed.

The practice had a relatively high dementia detection rate among the elderly population. The GPs were linked to the memory team in Crediton and worked alongside the community psychiatric nurses and dementia support workers. There were systems in place to maintain regular reviews of patients with dementia to ensure physical mental and social factors were monitored and then linked to appropriate services. The practice referred patients to the village memory café which was run by the charity Acorn. Patients with increasing needs were linked to the complex care team.

Summary of findings

What people who use the service say

We spoke with 16 patients in total. Ten patients during our inspection, two members of the patient participation group and after the site visit to four patients who had completed comment cards and said they would be happy to speak with us. We also spoke with a care home manager.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was made available for patients to share their experience with us. We collected 39 comment cards, all of which contained detailed, very positive and complimentary comments.

Patients knew how to contact services out of hours and said information provided at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy and dignity, used gloves and aprons where needed and washed their hands before treatment was provided.

Patients appreciated the dispensary and said they found it easy to get repeat prescriptions processed.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from January 2015 where 136 patients responded. The data from this survey showed patients were consistently satisfied with how they were treated and cared for; being consistently rated 'among the best' for its satisfaction scores on the service and consultations with GPs and nurses.

Outstanding practice

- Unannounced role play training had been additionally provided for staff to practice and review their response and skills when dealing with emergencies.
- The practice reached out to the community and supported and worked in partnership with a local charitable community support service (ACORN). The practice offered office space and resources to this charity who provided transport and prescription delivery in a rural area and offered services such as lunch clubs, coffee mornings and trips to the supermarket which reduced social isolation. The practice invited the coordinator of Acorn to the monthly multidisciplinary team meetings where the pastoral care, equipment provision and monitoring of vulnerable patients was coordinated.
- The practice was exceptionally caring. Patients said that staff went the extra mile and the care they received exceeded their expectations, this was in line with the practice track record of consistently being above national average data scores for patient care and treatment. Patients repeatedly referred to the service as being caring, respectful, exceptional, efficient and outstanding and shared many examples which supported that staff had gone above and beyond what was expected.
- Patients described the practice as being very responsive to their needs. Services were tailored to meet the needs of patients and were delivered in a way to ensure flexibility, choice and continuity of care. This responsive service had resulted in excellent survey results and significantly lower Accident and Emergency attendance rates.

Cheriton Bishop & Teign Valley Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a CQC pharmacy inspector, GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to Cheriton Bishop & Teign Valley Practice

Cheriton Bishop & Teign Valley Practice was inspected on Wednesday 15 July 2015. This was a comprehensive inspection.

The main practice is situated in the rural village of Cheriton Bishop, Devon and had a branch surgery in the village of Christow. We did not inspect the branch surgery on this occasion. The practice provides a primary medical service (PMS) across 80 miles to just under 5000 patients of a diverse age group. The practice are a training practice for doctors who are training to become GPs, for junior doctors and for medical students.

There was a team of two GP partners, two salaried GPs and one GP registrar. Partners hold managerial and financial responsibility for running the business. There were two male and three female GPs. The team were supported by a practice manager, two practice nurses, two health care assistants and administration staff.

Patients using the practice also had access to a community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open from Monday to Friday from 8am to 6pm. Appointments are available between these times and could be booked up to six weeks in advance. There is a walk in appointment system each weekday morning. Tuesday evening routine appointments until 8pm are available for people unable to access appointments during normal opening times. GPs also offered patients telephone consultations, ring backs and performed home visits where appropriate.

The practice had opted out of providing twenty four hour services to their own patients and when closed referred them by answer phone message to an out of hours GP provider.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

To get to the heart of patient experience of care, we always ask the following five questions of every service and provider:

• 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)

Before conducting our announced inspection of Cheriton Bishop practice, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and Northern Eastern & Western Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 15 July 2015. We spoke with 16 patients, three GPs, two practice nurses, a health care assistant, the practice manager, three members of the dispensary team and to members of the reception and administration team. We collected 39 patient comment cards. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and identified risks to improve patient safety by using information from reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of and explained their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff explained that significant events were used as a fact finding exercise and a training opportunity rather than apportioning blame. The minutes from staff meetings over the last two years showed that the practice had managed safety records and incident reports consistently and had safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of 20 significant events that had occurred during the last three years showed the system had been followed appropriately. Significant events were discussed at bi-monthly significant event meetings as well as actions from past events. There was evidence that the practice had learned from these and that the findings were shared with all staff including receptionists, administrators and nursing staff. For example, an event regarding results from a test had identified communication issues with the out of hours GP provider. Practice staff had discussed this as part of the significant event process. A decision was made about the timings of tests and action included changes in communication with the out of hours provider.

All opportunities for learning from internal and external incidents were maximised. Where there had been no events to review at a meeting the practice manager had used scenarios from other practices as a learning exercise. Where significant events had been raised as a complaint both processes were followed, so that the complaint was dealt with according to practice policy and the significant event policy was also adhered to.

Staff used incident forms on the practice intranet and sent timely completed forms to the practice manager. We tracked two incidents which had been completed in a comprehensive and timely manner, action had been taken and learning shared. Where things had gone wrong, patients were given an apology and informed of the actions taken to prevent the same thing happening again. For example, a potential missed diagnosis was reviewed and discussed. The practice had reviewed the case again to find that no changes could have been made, met with family and agreed an action plan to consider further investigations, should the situation recur.

National patient safety alerts were disseminated by email to practice staff. Staff confirmed that alerts were discussed at clinical meetings and action taken as needed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and knew how to share information, document safeguarding concerns and how to contact the relevant agencies. Contact details were easily accessible.

The practice had appointed specific GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The health visitor was based at the practice; this enhanced effective communication.

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

There was a chaperone policy, which was visible on the waiting room noticeboard ,in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks to identify whether they had a criminal record or on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Good

Are services safe?

Medicines management

Medicines were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines needing refrigeration were kept at the required temperature, which described the action to take in the event of a potential failure. Records showed that fridge temperature checks were carried out and medication were stored appropriately.

There was a procedure for ensuring that room temperature in the dispensary was suitable for storing medicines and a temperature control system was installed. Systems were in place to check that all medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Systems were in place to deal with any medicines alerts or recalls, and records kept of any actions taken.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. Medicines were scanned using a barcode system to help reduce any dispensing errors, and most items were also double checked by a second dispenser. All prescriptions for controlled drugs and medicines dispensed into blister packs were checked by a second dispenser. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

We saw a positive culture in the practice for reporting and learning from medicine incidents and errors. Incidents were logged efficiently and reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice had established a service for some patients to have their dispensed prescriptions delivered to other safe collection points, systems were in place to monitor how these medicines were delivered. They also had arrangements in place so that patients were given all the relevant information they required.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and staff followed standard procedures that set out how they were managed. For example, controlled drugs were stored in a controlled drugs cupboard to which access was restricted and keys held securely. There were arrangements in place for the destruction of controlled drugs. Weekly checks were undertaken to ensure that controlled drugs levels balanced with the register, and during our inspection a system was set up to record these checks.

Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Suitable emergency medicines were held at the practice, and checks were undertaken to make sure that they were available and suitable for use.

There was a system in place for the managing of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs), to administer vaccines and other medicines, that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the GP. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to.

The practice used liquid nitrogen. This was kept in a cupboard with appropriate signage. The cylinder was stored securely alongside guidance for transport and protective equipment for staff.

Cleanliness and infection control

The premises was clean and tidy. There were general cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff, which enabled them to plan and implement measures to control infection. There was personal protective equipment including disposable gloves, aprons and coverings available for staff to use and staff were able to describe how they would use these to

comply with the practice's infection control policy. There was also a policy and flow chart for needle stick injury, which had been reviewed within the last year. Staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control and all staff received induction training specific to their role and received annual updates. The last update was regarding effective hand washing. The infection control lead had carried out audits for each of the last three years and any improvements identified for action had been completed on time. The last audit in June 2015 had highlighted a need for improved hand washing guidance and wall mounted soap dispensers. The findings of the audits were discussed at clinical meetings.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and toilet areas.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). Records confirmed the practice was carrying out monthly checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was regularly tested, maintained, repaired or replaced promptly. Equipment records that confirmed all portable electrical equipment was routinely tested for safety and calibration and displayed stickers indicating the last testing date which was May 2015. We saw evidence of calibration or checks of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, defibrillator and the fridge.

Staffing and recruitment

The practice had a policy used for recruiting clinical and non-clinical staff. Records contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Staff explained that bank and agency staff were not used; they provided cover for each other as they preferred to offer continuity of care for patients. There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patient need.

There were enough staff to maintain the smooth running of the practice and keep patients safe.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

There were 38 separate risk assessments completed, each risk had been reviewed within the last year, assessed, rated and mitigating actions recorded. Risks associated with service and staffing changes (both planned and unplanned) were included on the log. Risks were discussed at GP partners' meetings and team meetings. We looked in detail at six assessments which included use of liquid nitrogen, storage of oxygen and staff stress, all were detailed and responsive.

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. Additional role play training had been provided for staff to practice their response and skills and review the procedures. One role play had resulted in locating the emergency medicines and equipment more centrally within the building and another had resulted in staff knowing how to access the disabled toilet door in an emergency.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The pads used with the automated external defibrillator were within their expiry date.

Good

Are services safe?

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. The inspection prompted a further addition to this process. All the medicines we checked were in date and fit for use.

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan was reviewed every month due to the detail and content. For example, contact numbers for each member of staff were recorded.

The practice had carried out a fire risk assessment in January 2015 which highlighted no actions required. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to patient 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. For example, practice nurses explained they used the NICE guidelines for asthma and chronic obstructive pulmonary disease (COPD) when carrying out a patient assessment. Staff explained new or amended guidance was downloaded from the NICE website and disseminated to staff at clinical meetings.

The GPs had developed many templates over and above those expected for routine health conditions.(Templates are documents used to support GPs during consultations so they follow best practice. For example, templates for coeliac disease and comprehensive geriatric assessments were used. Templates were also used by the GPs who inserted coils and manage hormone replacement therapy (HRT). We looked at examples of these templates, they were comprehensive, easy to use and aimed at enhancing patient care by holding all significant/relevant information as a result of prompts, they also had been used to generate recalls.

There were lead staff in specialist clinical areas such as diabetes, heart disease and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. Each vulnerable patient and those over the age of 75 had care plans in place and had a three monthly recall date or more frequent if required. The allocated GP received an email reminder and completed a review with either a visit or telephone call. Care plans were also reviewed and updated when patients were actively discussed at the MDT meeting to assist in reducing the need for them to go into hospital. These care plans were also inputted onto the out of hours system (with patient consent) to provide continuity of care.

Systems were in place to review patients who had been discharged from hospital to ensure that all their needs were continuing to be met. The manager from a care home said the GPs often arrived at the home to do this without having to be prompted.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about patient care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Clinical reviews were not limited to common diseases and conditions. The annual recall for all patients with chronic diseases, including non-QOF conditions also included hypothyroidism and coeliac disease.

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

The practice showed us many clinical audits that had been undertaken in the last three years. We saw examples where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit in 2012 on coeliac disease had been performed to ensure the patients were receiving the tests and treatments recommended. Re-audit was performed in 2013 and 2015. Findings had initially highlighted issues with data collection and coding and had identified an action to monitor investigation dates for some patients. Learning had also been shared with the other GPs in the practice and with the coeliac administrator. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Audits at the practice were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP

Good

Are services effective?

(for example, treatment is effective)

practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We saw an audit that had been performed to see whether there was a robust enough recall regarding hypothyroid patients and thyroid stimulating hormone monitoring since it had no longer been included in QOF monitoring. As a result systems were introduced to automatically call these patients for a blood test and re-audit five months later prompted discussions of how these patients could be reminded to attend for blood tests. Audit records showed how the GPs had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 100% of the total QOF target in 2014. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better than the national average. For example 91.81% of patients with diabetes at the practice had received a foot examination compared to the national average of 88.35%
- 4.62 per 100 patients on the disease register had been admitted as an emergency compared to the national rate of 7.4 per 100.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 90% which was similar but slightly better than the national average of 86.04%.

Data from the NHS England GP practice outcome were also above average compared to national and local CCG scores. For example:

- Identification of asthma score was 0.5 compared to a local average of 0.3 and national average of 0.34
- Dementia diagnosis score was 64.1 compared to local average of 52.7 and 58.14 national average.
- The score for the detection rates for cancer was 71.4 compared to local average of 51.2 and national average of 46.53.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance and local prescribing formularies.

Systems were in place for GPs to review patients receiving repeat prescriptions. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines or when dispensary staff were issuing repeat prescriptions.

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

The practice also kept a register of patients identified as being at high risk of admission to hospital, such as those in various vulnerable groups and patients with long term conditions. These systems were used to highlight patients who required reviews of their care, or medicines.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses and there was a culture which focused on staff development and training. As the practice was a training practice, doctors who were training to be GPs used extended appointments and had access to a senior GP throughout the day for support.

Practice nurses and health care assistants were trained appropriately to fulfil their duties. For example, on administration of childhood immunisations, cervical

Good

Are services effective?

(for example, treatment is effective)

cytology and travel vaccines. Those with extended roles such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken.

Working with colleagues and other services

The practice worked effectively with other service providers to meet patient need and manage those of patients with complex needs. Blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service reports were received both electronically and by post. Reports and results were all seen and actioned by a GP on the day they were received. Where the GP expected critical or urgent results to arrive out of hours the information regarding the patient was communicated. If a patient was seen during the day and was of concern to the GP but may not require admission at that time, the patient was given an admission note, and a note uploaded to the out of hours electronic record in case the patient required assistance when the practice was closed.

Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

A&E attendance figures were relatively low at a score of 56.3 per 1000 patients compared to the national average of 82.26. Emergency long term condition admission rates were also lower at the practice (14) when compared with the CCG (23) and nationally (23.47). The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, or patients from vulnerable groups or those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with OOH providers and other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours GP service.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. We were given examples of how a patient's best interests were taken into account if they did not have capacity to understand their choices and make a decision about their care and treatment. All clinical staff demonstrated a clear understanding of the Gillick competency test (used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

The practice used templates for documenting consent for specific interventions. For example, for childhood vaccinations verbal consent was documented in the child's electronic patient notes with a record of who gave consent

Good

Are services effective?

(for example, treatment is effective)

and who was present at the appointment. Written consent was obtained for minor surgery procedures where the relevant risks, benefits and possible complications of the procedure were explained.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 215 of patients in this age group took up the offer of the health check in the last year. We were shown the process for following up patients within a week if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 97.3% of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months. This compared to the national average of 95.28%.

The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 84.75%. This was above the national average of 81.88%.

There was a policy for telephone reminders for patients who did not attend for cervical screening test. The practice also encouraged patients to attend national screening programmes for bowel cancer and breast cancer.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 90.48% to 100% and five year olds from 85.71% to 100%. These were above national averages.

The practice website contained information for patients for home care of various ailments, such as coughs and colds and information of external websites including Asthma UK, Cancer UK and fit for travel websites.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from January 2015 where 136 patients responded.

The evidence from this survey showed patients were consistently satisfied with how they were treated and cared for. Data from the survey showed the practice was rated 'among the best' for its satisfaction scores on consultations with GPs and nurses. For example:

- 100% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 100% say the last GP they saw or spoke to was good at giving them enough time. This was higher than the local (CCG) average of 91% and national average of 87%.
- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%

The practice had also conducted a survey in 2012/13 with support from the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. (A PPG is a group of patients registered with a practice who work with them to improve services and quality of care). These results from 161 patients also gave consistently high results compared to national average results. For example, in all 28 questions patients scored the practice higher than other national results.

These findings were reflected in the 39 comment cards received. Patients repeatedly referred to the service as caring, respectful, exceptional, efficient and outstanding. Many comments included examples where the staff had gone above and beyond what was expected. For example:

- A prescription request from a patient had not given the dispensary time to order the medicines. The member of staff had got the prescription processed at another pharmacy 5 miles away and was delivered to the isolated patient in time for their next dose.
- When choosing private cars the GPs had decided to purchase 4x4 vehicles to assist them performing home visits in inclement weather.
- Staff regularly carried out regular fundraising activities and had raised over £12,600 to support the Acorn community support charity which provided care for their patients. The practice also provided office space at no charge for the charity.
- The GPs had often visited their end of life patients at weekends to provide reassurance and continuity of care.
- Staff regularly delivered dispensed medicines to vulnerable patients who are housebound or live in isolated settings. In recent poor weather, staff had delivered prescriptions and shopping to isolated patients.
- Staff had visited very vulnerable patients at home following missed appointments to ensure their wounds could be dressed.
- The PPG provided additional pastoral support for patients who had been discharged from hospital. For example, when the PPG members heard (from people in the village) that a vulnerable patient had been discharged from hospital they provided shopping services.

Patients also appreciated the friendly, professional, kind staff and said the facilities were clean and tidy. Patients referred to being satisfied, reassured and grateful for the attention and care they received.

These positive findings were consistently reflected during our conversations with the 16 patients we spoke with and from the practice's 478 friends and family test results from December 2014 to June 2015. Patients told us about their experiences of care and praised the level of individual care and support they received at the practice from all staff. Positive comments showed that patients thought the service was excellent, efficient and exceptional and that staff were kind, caring and professional. Patients told us that the GPs and nursing staff were excellent. Of the 478 friends and family test results, 476 patients said they were either extremely likely or likely to recommend the practice. There were two other results which stated patients were unlikely to recommend the practice. The reasons stated were lack of evening appointments. The practice had subsequently informed patients that weekly evening appointments were available.

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 patient privacy and

Are services caring?

dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patient treatment so that confidential information was kept private. The practice main switchboard was located away from the reception desk and was shielded, which helped keep patient information private.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice above average in these areas. For example:

- 96% said the last GP they saw or spoke to was good at involving them in decisions about their care. This was higher than the local (CCG) average of 87% and national average of 81%
- 98% said the last GP they saw or spoke to was good at explaining tests and treatments. This was higher than the local (CCG) average of 90% and national average of 86%

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

We saw notices in the reception areas informing patients that translation services were available and staff were alert to who may need help with translation.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 98% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 99% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 100% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 93% and national average of 91%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. Comments included times where staff had 'gone beyond the call of duty' and staff 'cannot do enough for you.'

Notices in the patient waiting room, and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified that just under 3% of patients were carers. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Information on the practice website informed patients that the practice were currently participating in a Devon Virtual Carers Centre initiative aimed at improving identification of carers. The practice provided clinical space at the practice for the group to provide health checks to patients who were carers.

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

Patients we spoke with who had been bereaved confirmed their relative had received very good support and said the GP had often visited without being asked which had been reassuring, had organised Macmillan nurses and the equipment needed. Patients also told us that after their relative had died the GP and practice staff continued to ask how they were.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and services were adapted accordingly. For example, the GPs recognised that transport links in the rural area prevented some patients having easy access to the practice and branch surgery. As a result, patients had easy access to appointments or telephone consultations with the GPs and home visits were offered.

The local NHS England team and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvement priorities.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the group had helped facilitate a service where hearing aid batteries could be collected from the practice rather than patients having to drive the 14 mile round trip to the acute hospital.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and walk in appointments were available for patients each day. The majority of the practice population were English speaking patients but access to online and telephone translation services if needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as consultation rooms and facilities were all on one level. There were access enabled toilets and baby changing facilities. There was a waiting area with space for wheelchairs and prams. This helped to maintain patient independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see either.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that it was regularly discussed at staff appraisals and team events.

Access to the service

Feedback from patients about access to the practice was consistently good. This feedback was provided in recent national surveys, patient surveys, friends and family test results and from conversations with patients. All patients we spoke with were happy with access to the practice.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service. However, we were informed of examples where the GPs had visited end of life patients at weekends, to provide reassurance and continuity of care.

Comprehensive information was available about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hour's service was provided to patients.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the local care homes on a specific day each week by a named GP and to those patients who needed one. Feedback from a care home was positive and included comments about the proactive service and compassionate care. The manager of the care home said home visits were never refused.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice above average in these areas. For example:

- 100% of respondents describe their experience of making an appointment as good compared with the local CCG average of 83% and national average of 73%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 100% said they could get through easily to the surgery by phone compared to the CCG average of 84% and national average of 73%.
- 100% of respondents say the last appointment they got was convenient compared with the local CCG average of 95% and national average of 92%

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day and usually their GP of choice. They also said they could see another GP if they preferred not to wait. Patients said they could request a ring back from the GP and this usually took place within two hours. Routine appointments were available for booking six weeks in advance. Patients had access to appointments each morning by using the walk in appointment service. The GPs explained that they did not mind seeing patients with minor issues at the walk in appointments as the patient could be reassured early, given health education or early diagnosis and prompt treatment.

Patients were able to request home visits and vulnerable patients were often visited without a request being made. For example we spoke with two patients who had received visits from the GP without requesting. The relative found this reassuring and said the GP would also phone to check everything was OK. This view point was reflected during conversations with a local care home manager. They said the GPs would often visit patients who had been discharged from hospital prior to a request being made.

The NHS England data showed that the access for patients had made a positive impact on emergency hospital admissions of patients with long term conditions. The practice value score was 14 compared to the local CCG average of 23 and national average of 23.47. A&E attendance rates were also lower at 56.3 compared with the local CCG average of 77.5 and national value of 82.26.

Listening and learning from concerns and complaints

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

We saw that information was available on the website, posters and leaflets, to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint, none of the patients we spoke with had ever needed to.

We looked at the only complaint received in the last 12 months and found it had been satisfactorily handled, dealt with in a timely way, with openness and transparency. An apology had been sent to the patient and the complaint had been formally reviewed to make sure any learning had been acted upon.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. The GPs said the ethos was that 'patients always came first.' Our discussions with patients and feedback confirmed that patients found this to be the case. We found details of the vision and practice values were part of the practice's strategy, described on the website and contained within the business plan.

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice was well organised. There were policies and procedures in place to govern activity and these were available to staff on the desktop on all practice computers. We looked at four policies and saw evidence that they had been reviewed annually, were up to date and staff had read them.

There was a clear leadership structure with named members of staff in lead roles, including leads for training GPs. We spoke with 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. Staff talked about mutual respect and a real sense of team work. Staff said it was a good place to work.

The GP partners took an active leadership role for overseeing that the systems in place to monitor the quality of the service were used consistently and effectively. These roles included leads for safeguarding, prescribing and governance, including a lead for the Quality and Outcomes Framework to measure the practice performance. The QOF data for this practice showed it was performing in line with national standards and often performed above local and national average. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to drive improvement, evidence from other sources, including incidents and complaints were also used for this. Additionally, there were examples where processes were in place to review patient satisfaction following feedback and to monitor quality.

The practice identified, recorded and managed risks. Where risks had been identified action plans had been produced and implemented. The practice monitored and acted on risks on a monthly basis. The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed and then reviewed to make sure action had been carried out.

The practice manager was responsible for human resource policies and procedures. We viewed the induction policy, staff training and safeguarding policy which were clearly written and up to date. We were shown the staff handbook and induction pack that was available to all staff, which included sections on whistle blowing, information governance and a guide to the practice.

Leadership, openness and transparency

The GP partners had a high profile and visible presence in the practice and staff told us that they were approachable and always took the time to listen to them. All staff were involved in significant event and complaint discussions and included when conversations were held about how to further develop the practice. Staff described the practice as being non-hierarchical and open to ideas.

We saw from minutes that team meetings were held every month. Staff had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the practice manager and partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients, staff and external stakeholders. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The active PPG included representatives from various population groups including working age members and mothers. The PPG had been running for four years and met four times a year. The practice manager showed us the analysis of the

Are services well-led?

Good

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

last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. The PPG had influenced change at the practice which included approaching the village councillors to provide more effective signage to the practice and had also carried out another survey to enquire why younger members did not consider joining the PPG.

The practice had also acted upon feedback from external stakeholders. For example, The practice had facilitated visits from a learning disabilities charity to give advice on the service and facilities including improved signage.

We saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice had scored highly but still used the results to see where further improvements could be made.

The practice had also gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had training sessions where guest speakers and trainers attended.

The practice was a GP training practice since 2013 and both partners shared the responsibility of being trainers. The practice had recently received a satisfactory deanery inspection report. One of the salaried GP was an approved appraiser of GPs. The GPs had scheduled in time to support the GP trainees and offer debrief sessions at the end of each session to discuss any difficulties experienced. Trainees were given longer appointment times to see and treat patients.