Wallingbrook Health Group

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Wallingbrook Health Group at Wallingbrook Health Centre at Chulmleigh on 23 March 2016. Overall the practice is rated as good.

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 reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- 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 management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw areas of outstanding practice:

- The practice drove innovation and was proactive in influencing this at a national level by having pioneered the role of pharmacist embedded in a GP practice. The practice had had a pharmacist as a partner since 2004 and had been an exemplar of best

Summary of findings

practice. The practice pharmacist has campaigned nationally for over a decade to promote the role of practice pharmacist as an integral part of GP practice teams.

- Staff were involved with innovation design projects such as the type 2 diabetes care pathway, which was due to be piloted across GP practices in England in the next 12 months into 2017. This resource aims to improve consistency, understanding, self care and shared decision making for patients with type 2 diabetes over the course of their life.
- The practice was proactive in identifying carers at the point of registering with them and had identified 5.1% of the practice list as carers.

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 an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients 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.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey 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 easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

- The practice was very proactive in identifying and supporting carers.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Wallingbrook Health Group had a higher proportion of older adults on the patient list compared with other practices in the area. Nearly half (46%) of the patient population were over 65 years, with a higher prevalence of chronic disease which the practice monitors. The practice area was predominantly rural with limited access to public transport. Secondary care referrals had to be made to two different Acute Hospital Trusts in Barnstaple and Exeter, which required staff to be conversant with protocols for both.
- There was a good skill mix across the staff team, which included: a nurse practitioner able to diagnose and treat patients with minor illnesses; a GP who was also an ophthalmology registrar at a local eye clinic and was able to treat low risk eye conditions at the practice. This meant patients could be treated closer to home avoiding trips to the hospital some considerable distance away.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- 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 evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- Practice Nurses provided home visits for patients who were unable attend the surgery and require annual chronic disease monitoring.
- Patients with learning disabilities and mental health problems were offered 30 minute reviews to ensure the patients' needs were met.
- Following feedback from patient surveys routine appointments for patients were increased to 15 minutes.

Are services well-led?

Good

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

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.
- The practice drove innovation and was proactive in influencing this at a national level. Examples included campaigning for pharmacists to be part of GP practice teams. In 2015 NHS England had committed £31m in their pilot to encourage more GP practice across England to employ practice pharmacists. Staff were involved with innovation design projects such as the type 2 diabetes care pathway, which was due to be piloted across GP practices in England in the next 12 months into 2017. This resource aims to improve consistency, understanding, self care and shared decision making for patients with type 2 diabetes over the course of their life.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- All patients had a named GP to promote continuity of care and when attending their appointments were collected by the GP or nurse from the waiting room.
- Monthly meetings were held between community staff, so that vulnerable older people were closely monitored and given timely support.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the national average. For example, 88.4% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months (national average 89.4%). The practice looked into a large variance between the practice and national percentages of patients with diabetes for some blood pressure readings. A plan was in place and completed actions included the setting up of a protocol so that GPs were alerted on the patient record system when the patient's blood pressure over 140/80 was recorded. Other actions included, on-going reviews and audits of patient outcomes on the diabetes register.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively comparable with those seen in the Clinical Commissioning Group (CCG) area for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 79.4%, which was above the CCG average of 76.9% but below the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Extended opening hours were not routinely provided on a specific day. The practice had consulted patients and instead offered working patients early morning and late evening appointments by arrangement to suit their needs. Information about this is listed on the practice website and patient information leaflet.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. This included, repeat prescription and appointment requests.

People whose circumstances may make them vulnerable

Good

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

Summary of findings

- The practice held registers of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. At the time of the inspection, there were no homeless people or travellers registered at the practice.
- The practice offered 30 minute appointments for patients with a learning disability. Reasonable adjustments made, including providing patients with easy read health plans following their annual review.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. Being situated in a rural area, the practice recognised that community services were under pressure and had listened to patients needs. Data provided by the practice showed that within the last 12 months, practice nurses had carried out 11 home visits to patients living in and around Chulmleigh and Winkleigh who were vulnerable, frail and/or had a long term condition. Patients had been reviewed and where needed simple interventions such as ear syringing were done to alleviate discomfort for patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

- 91.7% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was above the national average of 84%.
- Performance for mental health related indicators was similar to the national average. For example, 86.1% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (national average 88.5%).
- A system of a rolling programme of appointments was in place for patients with associated anxiety disorders, which was aimed at reducing their anxiety by providing a framework of planned follow up appointments for them.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia and provided 30 minute appointments for these.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Health Care Assistants at the practice had completed a dementia and mental health course, as some were involved in doing carers checks. All of the staff had a good understanding of how to support patients with mental health needs and dementia and shared several examples of how they had done so.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. Two hundred and thirty six survey forms were distributed and 133 were returned. This represented about 2% of the practice's patient list.

- 85.7% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 86.2% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 90.5% of patients described the overall experience of this GP practice as good compared to the national average of 85%).
- 85.5% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which were all positive about the standard of care received. Staff were described as being efficient, friendly and caring. Patients had confidence in the treatment and care they were receiving.

We spoke with 7 patients during the inspection. All 7 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Several told us that there were multiple generations of their family registered at the practice and the staff knew them well.

Outstanding practice

We saw areas of outstanding practice:

- The practice drove innovation and was proactive in influencing this at a national level by having pioneered the role of pharmacist embedded in a GP practice. The practice had had a pharmacist as a partner since 2004 and had been an exemplar of best practice. The practice pharmacist has campaigned nationally for over a decade to promote the role of practice pharmacist as an integral part of GP practice teams.
- Staff were involved with innovation design projects such as the type 2 diabetes care pathway, which was due to be piloted across GP practices in England in the next 12 months into 2017. This resource aims to improve consistency, understanding, self care and shared decision making for patients with type 2 diabetes over the course of their life.
- The practice was proactive in identifying carers at the point of registering with them and had identified 5.1% of the practice list as carers.

Wallingbrook Health Group

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, a second CQC inspector who was a pharmacist, and a practice manager specialist adviser.

Background to Wallingbrook Health Group

Wallingbrook Health Group has three registered locations providing general medical services at:

Wallingbrook Health Centre – Back Lane, Chulmleigh, Devon EX18 7DL

Winkleigh Surgery – 15 Southernhay, Winkleigh, Devon EX19 8DH

Okement Surgery - Cavell Way, Okehampton EX20 1PN (closing permanently on 30 April 2016)

The inspection on 23 March 2016 was of the Wallingbrook Health Centre at Chulmleigh. We also inspected Winkleigh Surgery on 5 April 2016 for which there is a separate report.

Wallingbrook Health Group practices are situated in a predominantly rural area. There were 8415 patients on the combined practice list, covering all three practices registered. The majority of patients are of white British background. All of the patients have a named GP. There is much a higher proportion of older adults on the patient list compared with other practices in the area. Nearly half (46%) of the patient population are over 65 years, with a higher prevalence of chronic disease which the practice monitors. The total patient population falls within the mid-range of social deprivation.

The practice is managed by six partners (four male and one female GPs, and a female harmacist).They are supported by two salaried GPs (male and female). If required the practice uses the same GP locums for continuity where ever possible. The nursing team consists of four female nurses; a nurse practitioner and three practice nurses. There are three female HCAs All the practice nurses specialise in certain areas of chronic disease and long term conditions management. The nurse practitioner is able to see patients with minor illness. All of the staff work across all three practice sites run by Wallingbrook Health Group.

The practice at Wallingbrook Health Centre in Chulmleigh is open 8.30am to 6.30pm Monday to Friday. Phone lines are open from 8.30am to 6pm, with the out of hours service picking up phone calls after this time. GP appointment times are from 8.30am to 11.15 am and 3pm to 5.15pm every weekday. The practice is not contracted to provide extended opening hours. However, the practice has consulted patients and instead offers working patients appointments on Monday and Wednesday evenings. Information about this is listed on the practice website and patient information leaflet.

Opening hours of the practice are in line with local agreements with the clinical commissioning group. Patients requiring a GP outside of normal working hours are advised to contact the out of hours service provided by Devon Doctors. The practice closes for three days a year for staff training and information about this is posted on the website.

The practice provides additional services, some of which are enhanced services:

Detailed findings

- Extended hours
- Minor surgery
- Risk profiling and reducing unplanned admissions.
- Annual health checks for patients aged over 14 years with a Learning disability.
- Facilitating early diagnosis of dementia
- Influenza, pneumococcal, rotavirus and shingles immunisations for children and adults
- Patient participation in development of services.
- Improving on line patient access.

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 23 March 2016. During our visit we:

- Spoke with a range of staff (GPs, practice nurses, practice manager, pharmacist and administrative staff) and spoke with 7 patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 25 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services 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 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 an effective system in place 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a significant event about the management of an unwell child, the practice found that, on examination, there were gaps in recording of the patient's temperature. A completed audit showed that this had improved by the second audit. The practice also created a template on the clinical patient record system to document findings when examining an unwell child. This had safety nets, which would not allow the GP or nurse practitioner to close the template unless all the required assessments had been completed and recorded. The approach provided assurances; for example, that a patients temperature was consistently documented. The practice had also shared this template with other practices within the North Devon Group that used the same patient record system.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and followed, illustrated by: the practice appropriately reported an incident to CQC and demonstrated throughout that patient safety was a high priority.Information showed that there was timely involvement of other agencies and when asked to do so, a robust investigation had taken place which was reported upon to relevant agencies. 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. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Six out of seven GPs were trained to child protection or child safeguarding level 3. We saw confirmation that level 3 training had been booked for a GP to bring them up to required standards.
- A notice in the waiting room advised patients that chaperones were available if required. 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 children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. There was a comprehensive system of regular infection control audits being undertaken at least every three months, which included: Hand hygiene assessments; sharps receptacle and waste disposal audits. We saw evidence that action was taken to address any improvements identified as a result, for example a cleaning audit demonstrated that cleaning staff had improved record keeping and provided the practice with assurance that equipment was appropriately laundered and stored.

Good

Are services safe?

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines).We saw the standard procedures were consistently followed at the practices in Chulmleigh and Winkleigh run by Wallingbrook Health Group. For example, some medicines were made up into blister packs to help patiens with taking their medicines, and safe systems were in place for dispensing and checking these.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs. We saw records demonstrating that the dispensary manager was in regular contact with the medicines optimisation team at the clinical commissioning group (CCG).
- Systems were in place promoting patient safety and wellbeing in regard of medicines. An example seen was a safety net for patients with asthma. A prescriptions trigger was in place, which alerted the practice if a patient had reached the set maximum of repeat requests for inhaler medicines, used to prevent and asthma attack. When this happened, the patient was invited for a review with the respiratory lead nurse who liaised with the patient's GP about the outcome.
- We reviewed three personnel files and found 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 Disclosure and Barring Service. Locum files were checked to ensure necessary checks and information was in place.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place 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).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice was well staffed for the number of patients registered there. The team had a wide skills mix.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- 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 and children's 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. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place 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

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place 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. For example, GPs carried out a search of all patients taking Bisphosphonates medicines (widely used to treat and prevent bone-related conditions). This had identified eight patients taking this medicine, who were then invited for a review. GPs had assessed all the patients, discussed associated risks and made changes where necessary to reduce these for patients.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 93.1% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the national average. For example, 88.4% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months (national average 89.4%).
- Performance for mental health related indicators was similar to the national average. For example, 86.1% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (national average 88.5%)

We looked at exception reporting of patients with dementia because this was significantly higher at 19% compared with the CCG (9.8%) and national (8.3%) averages in 2014/15. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Nearly half (46%) of the patient population are over 65 years, with a higher prevalence of chronic disease which the practice monitored. This was nearly double the national percentage of 27% of over 65s in other practices. The GPs recognised the increased risk of undiagnosed dementia with the ageing population at the practice. They demonstrated through examples that patients were screened and appropriate referrals were being made to secondary care specialists. They explained that the complex health needs of older patients often led to their inclusion in other registers so that their needs were monitored closely. Data for 2015/16 showed that only two out of 49 patients with dementia were exception reported, with justified clinical reasons for this. This also demonstrated an improvement on the previous years performance.

There was evidence of quality improvement including clinical audit.

- There had been 16 clinical audits completed in the last two years, seven of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, all patients diagnosed with asthma had been reviewed following a national report about preventable patient deaths from this condition. Patients had a face to face review, which included assessment of their inhaler technique and education to improve this where necessary.

Information about patients' outcomes was used to make improvements such as: Data for 2014/15 showed there was a large variance between the practice and national percentages of patients with diabetes for some blood pressure readings. The practice looked at all patients who in the last 12 months had a blood pressure reading of 140/80 mmHg or less to improve monitoring. The practice had 120 diabetic patients over 75 years which represented 30%

Good

Are services effective?

(for example, treatment is effective)

of the Diabetes register held. An education meeting had been held with the Clinical lead for Frailty, in which an NHS toolkit about frailty was discussed and GPs had considered the increased risk of falls from the overtreatment of hypertension in the over 75s. The practice had produced an action plan, which led to a protocol being set up so that GPs were alerted on the patient record system when the patient's blood pressure over 140/80 was recorded. Other actions included, ongoing reviews and audits of patient outcomes on the diabetes register.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- 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.
- 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. A GP was in the process of working towards the GPwSI (GP with Special Interest) Ear Nose and Throat qualification. This would enable them to provide an enhanced level of service closer to home for patients at the practice.
- Staff administering vaccines and taking samples for the cervical screening programme 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 nursing team carried out an annual peer review of cervical smears taken to ensure that their practice was within normal limits for inadequate samples taken. We saw three years of audits, demonstrating that all of results fell within the nationally agreed range.
- 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, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. 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

The information needed to plan and deliver care and treatment was 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.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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 when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

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 children and young people, 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 monitored through patient records audits.

Good

Are services effective?

(for example, treatment is effective)

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Patients were able to access talking therapies delivered by another provider at the practice.
- Patients who were new mothers were able to obtain support and learn massage techniques to use with their babies.
- The practice was participating in a unique weight management initiative commissioned by the local authority and managed by another provider. A healthcare assistant had received training and was approved to deliver a 12 week weight management service for patients referred to the programme. This could be extended for a further 12 weeks, if patients met certain criteria. Patients registered with the practice and other practices in the area who were eligible were referred to a central hub and then allocated the choice of where to receive the one to one support. Data showed that between August 2015 and April 2016, when patients progress was evaluated at 12 weeks by Devon County Council, 12 patients were supported at the practice and had lost a total of 76kg.
- Smoking cessation advice was available from practice nurses and information provided about a local support group.

The practice's uptake for the cervical screening programme was 79.4%, which was above the CCG average of 76.9% but below the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccines given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 91.7% to 100% and five year olds from 91.8% to 95.1%. The CCG rates for children under two ranged from 82% to 98.2% and for five year olds from 93.1% to 97%.

Patients had access to appropriate health assessments and checks. Up until recently, this included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. However, funding for these checks had stopped on 29 February 2016 by Devon County Council. As a result the practice no longer offered this service on site by the time we inspected.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed 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 appointments with patients; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 25 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four members of the patient participation group (PPG) at the practice in Chulmleigh. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average in most areas for its satisfaction scores on consultations with GPs and nurses. For example:

- 90.4% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90.2% and the national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 91.5% and the national average of 87%).
- 98.6% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96.7% and the national average of 95%)
- 89.4% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- 93.6% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 86.9% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90.4% and the national average of 87%)

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 listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 89.2% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.8% and the national average of 86%.
- 88.3% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 87.1% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%)

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

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

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 343 patients as carers (5.1% of the practice list). The practice was proactive in identifying carers at the point of registering with the practice. Patients written comments highlighted that staff knew them well. GPs told us that generations of the same family were registered at the practice and all patients had a name GP. They told us that this enabled them to identify carers needs quickly so that they could ensure they had appropriate support when needed. The Written information was available to direct carers to the various avenues of support available to them. Health care assistants had received dementia and mental health training and were registered 'Dementia Friends'. Some were responsible for doing carer checks and shared examples, such as a patient carer who they had helped to make contact with the local memory café so that they could have respite.

The practice provided space for a charity that reaches out to local communities to help people who are mentally, physically or socially isolated to improve their health, wellbeing and quality of life.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Wallingbrook Health Group had a higher proportion of older adults on the patient list compared with other practices in the area. Nearly half (46%) of the patient population were over 65 years, with a higher prevalence of chronic disease which the practice monitors. The practice area was predominantly rural with limited access to public transport. Secondary care referrals had to be made to two different Acute Hospital Trusts in Barnstaple and Exeter, which required staff to be conversant with protocols for both.

- Working patients who could not attend during normal opening hours were offered early and late appointments by arrangement to suit their needs.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available, which we saw being used effectively.
- There was a good skill mix of clinical staff, which enabled patients to access services closer to home. For example, a GP at the practice also worked part time as a secondary care ophthalmology registrar at a local hospital providing diagnostic expertise for patients with suspected eye conditions. The practice had specialist equipment, which enabled the GP to examine patients eyes in closer detail so that low risk treatments normally performed at the hospital could be done at the practice.
- The practice consultation, treatment and waiting rooms were all situated on the ground floor. The building was spacious and corridors wide enough for patients using wheelchairs and pushchairs.
- The practice demonstrated that staff understood how to promote the equality and diversity of all patients. We saw several examples such as: Patients who were undergoing the process of gender reassignment were supported to continue to access national screening programmes. Staff explained that patients would normally be removed from the nationally managed screening programme, for example if a female underwent gender reassignment to male. However, they supported patients throughout this period providing continued education of self checking and breast screening with them.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services. Leaflets to remind patient of referrals made provided patients with prompts and a safety net ensure these were acted on by secondary care services. Staff shared examples of how they supported patients with memory impairment by telephoning them regularly to prompt them to attend for appointments.

Access to the service

The practice was open 8.30am to 6pm Monday to Friday. Phone lines were open from 8.30am to 6pm, with the out of hours service picking up phone calls after this time. GP appointment times were from 8.30am to 11.15 am and 3pm to 5.30pm every weekday. Extended opening hours were not routinely provided on a specific day. The practice had consulted patients and instead offered working patients flexible appointments. Information about this was listed on the practice website and patient information leaflet.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 76.3% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 85.7% of patients said they could get through easily to the practice by phone which was above the national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.
- Home visits were carried out every day by GPs between clinics to patients needing them.Being situated in a rural area, the practice recognised that community services were under pressure and had listened to patients needs. Data provided by the practice showed that within the last 12 months, practice nurses had carried out 11 home visits to patients who were frail or had a long term condition.Patients had been reviewed and where neededsimple interventions such as ear syringing were done to alleviate discomfort for patients. A patient who had also been a carer for their spouse told us they had appreciated this level of support, which meant their relative could be seen in the familiar place of home and was more relaxed as a result.
- 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 an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, this included posters displayed and a leaflet available summarising the process in the waiting room.

We looked at seven complaints received in the last 12 months.We found all of these were satisfactorily handled and dealt with in a timely way. Written responses to patients from the practice demonstrated openness and transparency with dealing with the complaint. Lessons were learnt 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. The practice had reviewed the chaperone policy as a result of investigating a complaint and were disseminating the information about the changes to the whole team.

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 practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values of the stated aim: 'Together we build happy, healthy communities'.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice had pioneered the concept of pharmacists in general practice for more than 10 years, seeing the benefits for patients as a result of skill mix.One of the partners at the practice was a qualified pharmacist whose role included overseeing structured annual medicines reviews, including issues of polypharmacy (patients on multiple medicines) and those with complex health needs receiving medicines as treatment.
- When the practice moved into the current building, GP partners saw that Chulmleigh was an expanding community with a number of new houses being built.The practice had carefully planned the premises ensuring there was a large enough plot of land to expand the building to accommodate increasing numbers and changing needs of patients in the future.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.For example, the practice was managing the closure of its registered practice in Okehampton following an NHS England decision not to continue funding the service there.We saw considerable correspondence from the practice with all stakeholders, community teams and with patients affected.This demonstrated vigilance in managing risks, identification of vulnerable patients and escalation of concerns when some of these patients had not registered with an alternative practice to take over their health care.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. Weekly management meetings were chaired by an executive partner responsible for quality and governance. These meetings were attended by senior managers from each staff group. Minutes seen demonstrated that patient comments, complaints, feedback, and any operational planning issues were regularly discussed.

The provider was aware of and had systems in place 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 partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.
- We saw an example of records of a case conference following a complaint review by the ombudsman.This demonstrated that a thorough review had taken place, which raised awareness of taking a systematic and holistic approach when diagnosing a patient with multiple health concerns. An action plan had been put

Are services well-led?

Good

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

in place and was being completed when we inspected, which included ensuring that all clinical rooms were always equipped with thermometers, blood pressure and oxygen saturation monitors.

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

- Staff told us the practice held regular team meetings. Monthly meetings were held for each staff group and included a clinical meeting for GPs and nurses, part of which was used to review any significant events and discuss alerts and have educational updates.Minutes were kept of all the meetings and we saw a sample of these showing a clear communication system across all teams for any issues affecting the practice and patients. Staff interviewed told us that minutes of meetings were sent to them, so if they had missed a meeting they had been made aware of the issues discussed and any actions to be taken.
- 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. Two away days had been held and included: A partners away day for strategic review and planning; and a management away day to review and plan the goals and actions to achieve these for the forthcoming year.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners 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, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG was focussed on supporting the practice raising awareness of healthy living for improved health and well-being. A health booth was set up so that patients could do basic checks such as blood pressure, weight and set themselves five pledges to improve their health. The PPG ran a 'Healthy Living Week' in 2015 in which local sports providers offered taster sessions to all patients living in the community.These ranged from a parent/toddlers activity session, Tai Chi to tennis coaching and covered all age ranges. Another week was being planned for 2016 when we met members of the PPG.
- The practice had gathered feedback from staff through an annual staff survey, through staff training events and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged 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.

The pharmacist partner at the practice had campaigned nationally for GP practices to include a clinical pharmacist in their team. The pharmacist campaign and role was reported upon in a national paper in 2006 and led to recognition of the value for patients of having this role in practices. In 2015 NHS England had committed £31m in their pilot to encourage more GP practice across England to employ practice pharmacists.

The practice was an active member of the National Association of Primary Care, which is an organisation to support healthcare professionals to deliver change and spread innovation. Staff were leads on innovation design projects such as the type 2 diabetes care pathway, which was due to be piloted across GP practices in England in the next 12 months into 2017. Information seen highlighted that the diabetes care pathway aimed to provide an accessible signposting resource to help improve consistency, understanding, self care and shared decision making for patients with type 2 diabetes over the course of their life.

Nursing staff were actively involved in a locality nursing forum and used this as a platform to share innovation and

Are services well-led?

Good

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

implement change in their own practise at Wallingbrook Health Group. An example seen had improved the care and treatment of patients with complex wounds. Nurses had updated their skills through training and were able to do compression bandaging and had developed a template to record every contact with a patient so that there was detailed information about the wound, healing and treatments being used. The result of this was that there was increased consistency and communication across the nursing team, which was beneficial for patients being treated.