Yelverton Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Yelverton Surgery on 6 June 2017. 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 a system in place for reporting and recording significant events. This included learning from significant events that had occurred externally to the practice. For example, from parliamentary ombudsman investigation findings.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of and used current evidence based guidance. Staff had been recruited, appraised and trained to provide them with the skills and knowledge to deliver effective care and treatment.
  - There was evidence of effective communication at the practice. The practice held daily 'coffee mornings' where staff, including district nurses and other staff were invited to discuss clinical issues, teaching needs, emotional issues, management issues and review workloads.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
  - Feedback from health professionals and care home staff was consistently good.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with appreciated the telephone call back system used and said they found it easy to make an appointment with a GP and said there was continuity of care, with urgent appointments available the same day.
- The practice was clean, well maintained, had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Practice staff offered a family planning clinic which enable patients to be seen locally which saved a 20 mile round trip to the Plymouth family planning clinic or a 12 mile round trip to the Tavistock family planning clinic.
- There was a clear supportive leadership and management structure in place. The leadership team had developed a culture of inclusion, support and care for the staff group and other staff based at the practice.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The practice referred patients to external organisations effectively. For example, the local Memory Café, bereavement service and citizen advice bureau.
- The practice worked effectively with charities to ensure patients received the service they needed. For example, Yelvercare and Tavistock Area Support Services (TASS); two charities run by volunteers who offered transport and social events for patients.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We saw one area of outstanding practice:

The practice were committed to working collaboratively to ensure patients at the end of their life received coordinated care and ensured that care took into account their needs and preferences. For example, three of the GPs had previously worked within a hospice environment and were experienced in working with end of life patients and their families. Health care professionals said the GPs were proactive in providing appropriate symptom and pain relief medicines. GPs discussed patients who were at the end of their life during daily meetings, complex care meetings and met with a multidisciplinary team at least every two months. The practice were able to identify patients who were at the end of their life through 'pop up' information screens on patient records. The practice also offered a buddy system so if the named GP was unavailable the buddy GP would know about the patients care needs. The end of life lead GP performed an audit of deaths each year. The audit in March 2017 showed that 83% of all patients had died in their preferred place and 94% of these were at home.

The areas where the provider should make improvement are:

- Review systems for recording patients' consent to care and treatment to bring it in line with legislation and guidance.

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.

- From the sample of documented examples we reviewed, we found there was an effective system 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 were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice proactively used external significant events to improve processes in the practice. For example, an ombudsman report relating to a child death changed the way children presenting with a fever were managed at the practice; learning from this incident was also shared with other practices.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents. All staff including the cleaner had been included on the basic life support training.
- There was a detailed failsafe recruitment process in place. Records were organised efficiently and securely.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance and used national guidance effectively.
- The many clinical audits performed at the practice demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- New staff were supported and given a detailed induction. There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked effectively with other health care professionals to understand and meet the range and complexity of patients' needs.
- Feedback from health professionals was consistently good.
- End of life care was coordinated with other services involved.

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.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The GPs also treated staff with care and compassion.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a GP and there was continuity of care. Urgent appointments were 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. Evidence from the examples we reviewed showed the practice responded quickly to issues 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.

- The practice staff shared 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.

Summary of findings

- There was a clear leadership structure and staff felt encouraged and supported by management. The practice had policies and procedures to govern activity and held regular clinical meetings where governance issues were discussed.
- The practice held daily 'coffee mornings' where staff, including district nurses and other external staff were invited to discuss clinical issues, teaching needs, emotional issues, management issues and review workloads.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. We saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the virtual patient participation group who had worked with the practice to implement positive change.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients. For example, one GP had expertise in end of life care.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- The practice had 777 patients over the ages of 75 years and had, so far, undertaken 734 face to face consultations or telephone consultations with these patients (94%).
- The practice cared for 107 older patients across five nursing and care homes in the area. Named GPs were allocated to those care homes to provide consistency.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Older patients were discussed at coffee time, each day to identify care needs and prompt learning.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care. For example, Treatment Escalation Plans (TEP) forms were in place and reviewed with patients and their families.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. For example, the practice used ADASTRA (a system used by Devon Doctors out of hours provider) to share information with clinicians. Information on the ADASTRA system was regularly reviewed and updated by the practice.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- The practice worked with Yelvercare and Tavistock Area Support Services (TASS); two charities run by volunteers who offered transport and social events for patients. Representatives from TASS attended the practice regularly to offer a “drop in” service.

Summary of findings

- The practice referred patients to the local Memory Café, bereavement service and citizen advise bureau.
- The practice were committed to working collaboratively to ensure patients at the end of their life received coordinated care and ensured that care took into account their needs and preferences. As a result in March 2017 83% of all patients had died in their preferred place and 94% of these were at home.

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 long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for 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.
- Palliative Care meetings were held every six to eight weeks and two GPs shared the lead role of end of life care.
- Health care professionals were invited to speak with GPs at any time including the morning coffee meeting at the practice.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations. An administrator worked with the practice nurse, who then liaised with health visitors to identify

those children who miss immunisation appointments. Practice staff met with the Health Visitor and School Nurse every six to eight weeks to discuss families at risk, and to identify late/ missed baby checks or immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.

Appointments were available outside of school hours and the premises were suitable for children and babies.

- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people.
- A quiet room was available if mothers wished to breastfeed in private.
- Practice staff communicated with young people through the website, health information corner and leaflets provided in the toilets. Chlamydia testing was offered in a discreet and sensitive way.
- Young carers were identified in the same way as adult carers and through close working with the multi-disciplinary team.
- Practice staff offered a family planning clinic which enabled patients to be seen locally which saved a 20 mile round trip to the Plymouth family planning clinic or a 12 mile round trip to the Tavistock family planning clinic.

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 these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended hours appointments, use of the on line appointment and repeat prescriptions system, text reminders and telephone consultations.
- Saturday morning practice nurse appointments were offered every five weeks.
- 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.

Summary of findings

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- All patients with a learning disability had received a health check in the last year.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients who needed them many were visited in their homes by a GP and health care assistant. A small number of patients could also be seen by two GPs where the patient had complex care needs.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- The practice offered a room for patients to meet with the Drug and Alcohol team rather than them having to travel a 104 mile round trip to similar services in North Devon.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice used 'pop up' notes to remind staff of specific information. For example if a patient was deaf or where there was a safeguarding concern or risk of domestic violence or violence in the practice. Pop ups were also used where patients should only be seen by the GP rather than GP registrars.

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).

- Double appointments (or longer if necessary) were offered to patients with mental health issues to enable them time to discuss issues.
- 100% of patients on the practice mental health register had a health check and care plan review in the last year.

Summary of findings

- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice offered a room for mental health professionals, counsellors and depression and anxiety counsellors to use.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Practice staff referred patients to the Young Devon Counselling Services, counselling at schools through school nurses, and to the RISE (Recovery and Integration Service -local drug and alcohol team)
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice carried out advance care planning for patients living with dementia.
- 88% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average.
- The practice were working towards becoming a Dementia Friendly practice with several staff having become Dementia Friends. The practice had also applied to join the Plymouth and West Devon Dementia Alliance.
- Patients at risk of dementia were identified and offered an assessment.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2016. The results showed the practice was performing in line with local and national averages. 218 survey forms were distributed and 136 were returned. This represented about 2% of the practice's patient list.

- 93% of patients described the overall experience of this GP practice as good compared with the CCG average of 90% and the national average of 85%.
- 91% of patients described their experience of making an appointment as good compared with the CCG average of 81% and the national average of 76%.
- 92% 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 87%.

The practice also performed an internal survey which went live on the website on 30 November 2016 and lasted until 23 January 2017. Findings showed:

- 94% of respondents said the receptionists were very helpful or helpful.
- 93% of patients rated the ability to contact the practise on the telephone as either excellent, good or very good.
- 73% were able to see or speak to the Doctor of the patients choice?
- 85% said excellent, good or very good at explaining tests and treatments to patients.
- 87% of patients said the nurses gave patients enough time

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received eight comment cards. All of the eight patient Care Quality Commission comment cards we received were positive about the service experienced. Comments were detailed and indicated that patients were happy with the service, staff and premises. Comments included feedback about staff being 'efficient', 'cheerful' and 'understanding'. Comments about the care and treatment included service being 'first class', 'superb' and 'excellent'.

We spoke with eight patients and received five emails from members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted care and treatment was 'superb', 'excellent' and 'faultless' and added that visits to the practice were 'a pleasant experience'. Reception staff were described as 'friendly', 'helpful' and 'efficient.'

We looked at the 15 friends and family test results received in the last three months. All 15 results showed patients were extremely likely or likely to recommend the GP practice. All comments were positive.

Areas for improvement

Action the service SHOULD take to improve

Review systems for recording patients' consent to care and treatment to bring it in line with legislation and guidance.

Outstanding practice

The practice were committed to working collaboratively to ensure patients at the end of their life received coordinated care and ensured that care took into account their needs and preferences. For example, three of the GPs had previously worked within a hospice environment and were experienced in working with end of life patients and their families. Health care professionals said the GPs were proactive in providing

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appropriate symptom and pain relief medicines. GPs discussed patients who were at the end of their life during daily meetings, complex care meetings and met with a multidisciplinary team at least every two months. The practice were able to identify patients who were at the end of their life through 'pop up' information screens on patient records. The practice also offered a buddy system so if the named GP was unavailable the buddy GP would know about the patients care needs. The end of life lead GP performed an audit of deaths each year. The audit in March 2017 showed that 83% of all patients had died in their preferred place and 94% of these were at home.

Yelverton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Yelverton Surgery

Yelverton Surgery is located in the village of Yelverton, Devon and covers a large rural area extending from the north of Plymouth across to Dartmeet and Hexworthy in the east and Grenofen to the west. Yelverton Surgery provides a personal medical service (PMS) which provides a service to approximately 7,250 patients. 800 of these patients usually see a GP at the branch surgery in Princetown and approximately 750 of these 800 patients use the dispensing service provided.

The practice population is in the eighth decile for deprivation. In a score of one to ten the lower the decile the more deprived an area is. There is a practice age distribution of male and female patients equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 79 years and females living to an average of 84 years.

The practice has five GP partners, three of which are female and two are male and two GP registrars, both of which are female. (Whole time equivalent of 4.5 GPs) The GPs are supported by two practice nurses, a health care assistant, a practice business manager and a practice operations manager as well as additional administration and reception staff.

Patients using the practice also have access to community staff including community nurses, who are based at the practice, podiatrist and a physiotherapist. Other visiting staff use the facilities at the practice. For example, in house counsellor and drug and alcohol support worker.

Yelverton Surgery is a training practice and has doctors training to become GPs working at the practice. There are three GPs who support trainee GPs and registrars. One GP is shortly to qualify as an academic tutor. The GPs also teach 3rd and 4th year medical students. Two named GPs are responsible for this teaching

The Yelverton Surgery practice is open between 8am and 6pm Monday to Friday. Appointments are available from 8.30am to 10.30am every morning and 3pm to 5pm daily. Extended hours appointments are offered most Saturday mornings from 8.30am until 10.30am with practice nurses providing a Saturday morning clinic every five weeks.

A GP telephone call back service is available every morning between 8.00am and 10.00am. Daily telephone consultations are available to discuss routine problems including test results and referrals. These can be booked in advance between 11.30am and 12.30pm. Routine appointments can be booked up to three months in advance. A 'duty' GP works at the practice each day.

The practice has a branch Surgery in Princetown Village Centre which is open between 8.30am and 9.40am every Monday, Wednesday and Friday. Patients can book one of the four pre bookable appointments or can 'sit and wait' to be seen. The GPs see approximately 15 patients per session at this branch. There is a dispensary at Yelverton and a very small dispensary at Princetown surgery. Both dispensaries provide a service for Princetown patients only.

During evenings and weekends and when the practice is closed, patients are directed to dial NHS 111 to talk to an Out of Hours service delivered by another provider.

Detailed findings

The following regulated activities are carried out at the practice; Treatment of disease, disorder or injury; Surgical procedures; Family planning; Diagnostic and screening procedures; Maternity and midwifery services.

The main practice is located at: Yelverton Surgery, Yelverton, Devon, PL20 6AS

The branch surgery operates out of rooms in the Princetown Community Centre, 1 Moor Crescent, Princetown, Yelverton PL20 6RF.

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 6 June 2017. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited the main practice location
- Looked at information the practice used to deliver care and treatment plans.
- Spoke with staff from two care homes the day before our visit and to three healthcare professionals who were at the practice on the day of inspection.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We looked at the matrix of 41 significant events received between April 2016 and March 2017. We reviewed safety records, incident reports, patient safety alerts and minutes of clinical meetings where significant events were discussed as a standing agenda item. All staff, including district nurses were invited to these meetings.
- We saw staff were given positive feedback when events went well and also saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a test result had been scanned into the wrong patient records. Once this was identified the results were removed from wrong patient's notes and scanned into the correct patient records. No harm came to the patient. Learning included reminding all staff to double check patient details and action was taken to amend the specimen protocol and ensure the review was highlighted to all staff.
- The practice also monitored significant events to identify any trends. We looked at the spread sheet and did not identify any trends.
- The practice proactively used external significant events from other practices to improve processes in the practice. For example, a parliamentary ombudsman report relating to a child death from sepsis had changed the way children presenting with a fever were managed at the practice.
- The practice also notified external providers when experiencing issues outside of the control of the practice. For example, a GP experienced an engaged telephone tone when attempting to call an emergency ambulance. The incident was reported to NHS England and a thorough investigation of telephone lines was performed to discount any telephone line faults.

Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements for both the Plymouth safeguarding area and Devon area. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses were trained to level two and administration staff to level one.
- Notices in the toilets and waiting rooms 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. The practice employed their own cleaner who was seen as part of the team.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. Patients told us the premises were always 'spotless'.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were

undertaken and we saw the last audit in January 2017 showed that action had been taken to address any improvements identified as a result. For example, changing surface wipes used for cleaning.

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

There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

Blank prescription pads were securely stored. Recent changes to the records kept for monitoring of blank prescription forms and pads meant this stationery was more securely monitored. GP rooms where prescriptions were generated were not always locked but there was a practice to remove this stationery when GP were not working from the room.

Both practice nurses had qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow non prescribing nurses to administer medicines in line with legislation.

Systems were in place to ensure patients had annual medication reviews. Data provided by the practice showed that the percentage of patients who had received an annual review in the last year were:

- Diabetes over 90%
- Chronic Obstructive Pulmonary Disease 98%
- Rheumatoid Arthritis 97%
- Dementia 84%

There was a dispensary at Yelverton which served approximately 800 patients in Princetown. Approximately 750 patients used the service with the remaining 50 opting to use alternative pharmacies of choice or those closer to a place of employment. 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 operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). The practice used the Dispensary Services Quality Scheme (DSQS). Competencies were complete for each dispenser.

The practice was a dispensing practice and performed DRUM reviews (dispensing review of use of medicine) on 10% of the population dispensed to each year. This totalled 80 patients in varying patient groups.

GPs and nursing staff were able to access stock medicines from the dispensary. Dispensing staff were in the process of introducing additional safety checks when these staff removed medicines.

We reviewed five personnel files and found files were efficiently organised and detailed to allow clear auditing and monitoring to take place. We saw evidence to show that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment which had been carried out in April 2017 and had last carried out a fire drill in December 2016. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. The last PAT (portable electrical testing) test had been done in July 2016 and the last equipment calibration test had been performed in November 2016.

Good

Are services safe?

- The practice had a variety of other risk assessments to monitor safety of the premises. For example, the last environmental risk assessment had been carried out in September 2016**.** A risk assessment for legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) had been performed in November 2016.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a staffing policy and rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents. We were given two examples where practice staff had successfully responded to emergencies:

- A receptionist had noticed a patient, who had suffered a bee sting, deteriorate whilst in the practice and summoned immediate help; the patient suffered an anaphylactic shock in the practice. The patient was successfully resuscitated before the ambulance service arrived
- A baby became "floppy" whilst seeing a doctor; the baby was successfully resuscitated before the ambulance service arrived.

All staff were aware of what to do in an emergency. 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. It had been identified that for a 45 minute period each day a receptionist and the cleaner were the only additional member of staff in the practice with a GP. As a result the cleaner had also been included on the basic life support training.
- 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. We found several items of emergency equipment and an item in a doctors bag that had expired. We were informed the practice were in the process of extending the method used to check emergency medicines to include doctors bag contents and the emergency equipment used.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan had been reviewed in January 2017 and included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- Any changes were discussed at clinical meetings and emailed to staff.

The nursing team led the management of chronic disease. Patients were given care plans recommended by the charities Asthma UK and Diabetes UK which were based on NICE guidelines. Advice given and or copies of care plans were stored in patient notes.

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 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was higher than the CCG and national averages. For example the percentage of patients with diabetes, on the register, where a blood sugar recording was within normal limits in the preceding 12 months was 88% compared to the CCG average of 81%and the national average of 78%
- Performance for mental health related indicators was higher than the CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 98% compared to the CCG average of 87% and the national average of 89%.

There was evidence of quality improvement including clinical audit:

- We looked at 10 clinical audits commenced in the last two years. Four of these were completed audits where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, current evidence suggested that Hormone Replacement Therapy (HRT) in women over the age of 60 years should be provided in a way which releases a continuous amount of hormone. The practice audit had been performed twice in the last year and highlighted two women who needed a review of their medicines which had been undertaken.
- Clinical audits were used to respond to concerns with effectiveness of the service. For example, a patient had requested information on the date their contraceptive device was due to be changed. The staff realised a code had not been used to remind GPs to alert the patient. As a result a search was performed on all patients using this device. The 33 patients were identified as requiring no further action. Nine of the remaining patients were identified as needing a further appointment within three months. They were contacted with an apology and reminder to make another appointment and advised to use another form of contraception until their appointment. Further action included scheduling a re-audit in six months time.

GPs and clinicians attended a daily 'coffee morning' meeting. The relaxed meeting was open to all staff to attend and was seen as a multifunctional time to discuss:

- Ethical issues
- Clinical problems where GPs and clinicians could discuss complex cases to ensure safe and effective care was being delivered.
- Teaching needs of any medical students or registrars
- Visits for the day
- Emotional support
- Complaints
- Management issues.

The coffee morning meeting was also used to peer review all referrals to ensure these were appropriate and had captured all information needed.

Good

Are services effective?

(for example, treatment is effective)

A clinical meeting was held every three months. All staff, including GP trainees, district nurses and locum staff were included in these meetings. A standing agenda ensured vulnerable patients and safety issues were discussed. The agenda included:

- Complex cases where medical dilemmas were discussed
- Learning disability reviews and dementia performance progress
- Training needs
- Medicine changes
- Top tips
- Significant events

Other items included in the examples we looked at were discussions about medicines in schools, domestic violence and the flu campaign.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. New staff told us this process had been detailed and that the GP partners and practice manager had been very supportive. The programme covered such topics as safeguarding, infection prevention and control, fire safety, information governance, 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. Another example demonstrated external training had included updates on immunisations, ear syringing, leg ulcers and contraceptive devices.
- 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. Both practice nurses and two female GPs were able to perform cervical screening.
- 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, and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months or had a date scheduled within the next two months.
- The practice used the 'Productive GP' education and quality programme run by NHS England. The staff had done two back office modules including notes management and prescription management.
- 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. One of the GPs worked for the out of hours provider so was able to communicate to the GPs what information was particularly important to include on the shared 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. Patients said any referrals to secondary services had been done so efficiently.

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. Information was shared between services, with patients' consent, using a shared care record. 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. We spoke with two representatives from two care homes who said the working relationship between the practice staff and care home staff was effective and responsive. One professional said the GPs responded promptly to requests for home visits or feedback. We also spoke with three nurses from the district

nursing team who were based at the practice. They said communication with practice staff was effective and requests for medicines and home visits were acted on promptly.

The practice ensured end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Three of the GPs had previously worked within a hospice environment so had the experience to work with end of life patients and their families. Health care professionals said the GPs were proactive in providing adequate symptom and pain relief medicines. For example, syringe drivers and 'just in case' medicines. A multidisciplinary team meeting consisting of district nurses, MacMillan nurses, GPs, and practice manager were held at least every two months, although the team could access the GPs in between these meetings. Information regarding patients at the end of their life were communicated to staff using 'pop up' information screens on the patient records and were also discussed at complex care meetings and during the daily coffee morning meetings. The practice also offered a buddy system so if the named GP was unavailable the buddy GP would know about the patients care needs. The end of life lead GP performed an audit of deaths each year. The audit in March 2017 showed that 83% of all patients had died in their preferred place.

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. Information posters and guidance was available for staff to use and more formal e-learning was provided.
- 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.
- Patients told us the staff always asked permission before carrying out any procedure or treatment. We saw records to show that written consent was obtained for minor surgical procedures, with the exception of joint injections. Nurses said they recorded consent as free text within patient records and had a process to obtain verbal or written consent from parents if they were not attending for child immunisations. The process for seeking consent was not currently monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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.

The practice's uptake for the cervical screening programme was 82%, which was comparable with the CCG average of 82% and the national average of 81%. Both nurses and two female doctors were able to take smears. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. There were failsafe systems 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 immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 93% to 96% and five year olds from 92% to 93% compared to the national expected coverage of vaccinations which was 90%.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. 79% of women who had been invited had attended breast screening in the last 36 months which was higher than the national average of 72%. 67% of eligible patients between the ages of 60 and 69 had been screened for bowel cancer in the last 30 months which was higher than the national average of 58%.

Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice kept written records of written correspondence. Written correspondence and documents

Good

Are services effective?

(for example, treatment is effective)

including normal test results were sometimes managed by the administration staff. On the day of inspection these staff were receiving additional training to understand common test results. There was no monitoring of this process at present but the GPs were considering introducing an audit system to check these had been appropriately managed.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the eight patient Care Quality Commission comment cards we received were positive about the service experienced. Comments were detailed and indicated that patients were happy with the service, staff and premises.

We spoke with eight patients and received five emails from members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

- 90% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 92%
- 90% 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%.
- 97% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 91%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 94% 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%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG average of 91% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. We spoke with two representatives from two care homes who said the GPs and staff at the practice were very kind and respectful when treating patients.

The kindness and caring culture of the GPs and practice manager also included caring for the workforce. Staff told us that emotional matters could be discussed at the 'coffee morning' each day and added that the duty GP had a role to go round the building at the end of each day to check on the welfare of each member of staff.

The leadership had a caring approach to its staff and other professional colleagues and hosted a Christmas party each year and promoted social activities and team building events amongst the staff group. District nurses said they were seen as part of the team and were included in these events.

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. The practice was in close proximity to a large acute hospital and therefore had a large number of medical staff as patients. We spoke with two of these patients who said staff listened and valued their involvement in care and treatment decisions.

Patients 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.

Good

Are services caring?

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:

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 91% 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%.
- 92% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 92% 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 interpretation services were available for patients who did not have English as a first language. We saw notices in the treatment rooms informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

The patient participation group had requested additional information and an information corner had been introduced with 'hot topics' regarding health information.

Information for discreet sexual health screening was provided in toilet areas.

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. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

Carers were identified through the new patient questionnaire, the GPs and other members of the multi-disciplinary team. Patients could also register using an online form on the website. The practice's computer system alerted GPs if a patient was cared for and also a carer. The practice had identified just over 2% of patients who were carers and just over 2% of patients who had a carer. Written information was available to direct carers to the various avenues of support available to them.

The practice worked with Devon Carers to identify those who might benefit from further support either as a carer or a person who is being cared for. The Devon Carers Support Worker attended the practice on a fortnightly basis. A lead administrator maintained the register of carers.

Staff told us that if families had experienced bereavement, staff would be notified through the use of a notice board within the office area. The patients usual GP contacted the relative 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 understood its population profile and had used this understanding to meet the needs of its population. The practice is situated in a rural location and was a minimum of 12 miles to the nearest acute hospital.

- The practice offered extended hours most Saturdays from 8.30am until 10.30am for working patients who could not attend during normal opening hours. Saturday appointments with the practice nurse were offered every five weeks.
- The practice had worked with the Rotary club in Yelverton to facilitate the community defibrillator. A number of patients had received training in emergency life support and a further number were on a waiting list.
- There were longer appointments available for patients who needed them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.

Access to the service

The Yelverton Surgery practice is open between 8am and 6pm Monday to Friday. Appointments are available from 8.30am to 10.30am every morning and 3pm to 5pm daily. Extended hours appointments are offered most Saturday mornings from 8.30am until 10.30am.

The branch practice, Princetown Village Centre Surgery offered four pre bookable appointments and additional 'sit and wait' appointments open every Monday, Wednesday and Friday mornings.

In addition to pre-bookable appointments that could be booked up to three months in advance, urgent appointments were also available for patients 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.

- 80% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 99% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 91% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 85% and the national average of 76%.
- 99% of patients said their last appointment was convenient compared with the CCG average of 95% and the national average of 92%.
- 90% of patients described their experience of making an appointment as good compared with the CCG average of 83% and the national average of 73%.
- 83% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 64% and the national average of 58%.

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

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

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.

Data provided by the practice showed the GPs averaged 7to10 home visits per day. These were allocated during the coffee morning and triaged in the order of priority.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We spoke with the district nurses based at the practice and with two care home staff who agreed that requests for home visits were never refused.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, information was provided on the practice website and within patient posters in waiting areas.

We looked at five complaints received in the last 12 months and found all complaints had been satisfactorily handled and dealt with in a timely way. Responses seen were transparent when dealing with the complaint and contained apologies and opportunities for patients to meet with practice staff where appropriate. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a delay in patient receiving medicines had resulted in staff being reminded to follow up when correspondence to hospital staff were not responded to.

Are services well-led?

Good

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

Our findings

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Vision and strategy

All practice staff had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a philosophy to 'deal with todays work today'. The practice had a mission statement to treat every patient with compassion, dignity, respect and without discrimination.
- One of the aims of the practice was to provide a high quality supportive training environment for all training doctors, nurses, medical students and allied staff; so that they learn and acquire excellent skills and attitudes. Feedback from trainee doctors confirmed this took place.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

We saw a culture, behaviours and routines which current partners said had been inherited from previous partners at the practice. The GPs said this positive culture had continued after previous GP trainees had become partners. For example, the daily coffee mornings and welfare checks at the end of each day.

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 and ensured that:

- There was a clear leadership, responsibility roles and staffing structure in place. Staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, prescribing, safeguarding and end of life care.
- Practice specific policies were implemented and were available to all staff. These were in the process of being updated and reviewed.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings, team meetings, clinical meetings and more informal coffee morning meetings were held which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of regular structured clinical, partnership and staff meetings that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners and management team 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. Staff appreciated the 'open door' attitude of all the GPs and practice manager.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. We found that the practice had systems 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.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns. District nurses were situated within the practice and said communication with practice staff was excellent. The nurses added they were invited to the daily coffee

Are services well-led?

Good

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

morning meetings and were included on any internal training sessions and the clinical meetings where significant events and complex care patients were reviewed.

- Staff told us the practice held regular team meetings.
- 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. Minutes were comprehensive and were available for practice staff to view.
- 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

Patients appreciated the communication from the practice and valued the practice website and newsletters.

The practice encouraged and valued feedback from patients and staff. It proactively sought 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, an internal survey between November 2016 and January 2017 resulted in a health information corner being introduced in the waiting room.
- the NHS Friends and Family test, complaints and compliments received
- staff 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 GPs introduced the telephone triage system in 1995 before many other practices and had supported other practices in the area to introduce the system. The GPs used the telephone system and their experiences working as out of hours GPs to teach GP registrars about effective and safe triage.