Whipton Surgery

Inspection report

378 Pinhoe Road
Exeter
Devon
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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 location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Outstanding**
Are services well-led?	**Good**

Overall summary

This practice is rated as good overall (outstanding in the responsive domain). (The previous inspection was in July 2015 where we rated the practice as good overall and outstanding in caring)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive at Whipton Surgery on Monday 21 May 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Medicines were managed well at the practice and prescribing rates and patterns were kept under review to ensure safety.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients gave detailed positive feedback about the care and treatment they received. Results from the July 2017 national GP patient survey, friends and family test results, CQC comment cards and independent survey results were all positive. Of the 60 CQC comment cards we received and interviews with six patients, all were positive about the staff group, access, care and treatment received. There were no negative comments received.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice continued to be a popular teaching and training practice, with all four partners registered as trainers.
- Staff said the practice was a good place to work and added that the leadership team were supportive and encouraged career development and learning to help improve patient safety.
- There was evidence of systems and processes for learning, continuous improvement and innovation. The practice had taken part in local pilots and research.
- Networking continued to be a priority of leaders and staff to deliver safe, effective, caring and well led service. For example, the practice manager was the LMC (Local medical council) pastoral support officer and director of finance for the Exeter Primary care federation.

We saw an area of outstanding practice:

The practice nurse provided a complex wound dressing service and the clinical team had introduced a domiciliary visiting nursing service for patients whose needs did not meet the threshold of the community nursing teams. 82 home visits from the practice nurse in seven months had been completed to offer additional services including ECG (Heart tracing), nebuliser treatment, urgent blood tests and long term condition monitoring. The nurse had been runner up in the local 2018 Practice nurse of the year award for this service.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

Older people	Good
People with long-term conditions	Outstanding
Families, children and young people	Outstanding
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Outstanding

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser.

Background to Whipton Surgery

Whipton Surgery is a GP practice which provides services for approximately 4100 patients. The main practice is situated in the city of Exeter, Devon.

The practice population area is in the fifth decile for deprivation. In a score of one to ten, the lower the decile the more deprived an area is. The practice distribution of male and female patients is equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 81 years and females living to an average of 85 years.

There is a team of four GP partners (three female and one male). The GPs together provide 22 sessions per week.

The team also includes a practice manager, five administration/reception staff, two healthcare assistants/ phlebotomists, one practice nurses and additional cleaning staff.

Patients using the practice have access to community staff including community nurses and health visitors. Patients could also access counsellors, depression and anxiety services, alcohol and drug recovery workers, voluntary services and other health care professionals.

The practice is a training practice for GP Registrars (doctors training to become a GP) and has received positive feedback from the medical school.

When the practice was closed telephones were transferred to the local NHS 111 service. Details of this could be found on the practice website and posters displayed in the practice.

The practice is registered to provide regulated activities which include:

Treatment of disease, disorder or injury, surgical procedures, family planning, maternity and midwifery services and diagnostic and screening procedures and operate from the location of:

Whipton Surgery

378 Pinhoe Road

Exeter

Devon

EX4 8EG

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods, untoward emergencies and epidemics. For example, this winter's inclement weather had resulted in staff and GPs appropriately and safely prioritising patient care and delegating work and home visits.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Posters within patient waiting rooms helped patients to recognise the symptoms of sepsis and provided guidance about what actions they should take. Staff had received training and had access to written guidance in each treatment and consultation room.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The embedded checking systems for managing and storing medicines, including vaccines, emergency medicines and equipment minimised risks.
- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients whom required regular monitoring received reviews to reduce risks due to medicine complexities were involved in regular reviews of their medicines. Medicine monitoring at the practice was provided by GPs. The practice worked with the community pharmacist for medicines management and had been instrumental in obtaining funding for a Clinical Commissioning Group (CCG) pharmacist.

Good

Are services safe?

- The GPs at the practice met with a community services pharmacist every six weeks to discuss patient medicine management. We received positive feedback about the professional and personable staff group who had 'patients best interests at heart.'

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped them to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned from and made improvements when things went wrong. The practice also reflected where responses to emergencies or significant events had gone well.

- Staff understood their duty to raise concerns and report incidents and near misses and told us that leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services.

Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice. For this period the practice had obtained 100% of points available and recognised the overall exception reporting rate was slightly higher than national and local averages. For example, 10% compared to local averages of 7% and national averages of 6%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

To understand the exception reporting we looked at patient records, spoke with staff and identified a lower compliance rate and high rate of declined services. We saw there were systems in place to send patients reminder letters, offer ad hoc screening and provide double appointments to provide a more flexible service for patients. The practice had also set up a domiciliary nursing service to provide care, treatment and screening for patients who were unable to visit the practice and for those patients likely to miss appointments.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used many templates within the computer system to prompt staff to capture and record investigation and test results for patients. These included diabetic screening, asthma reviews and templates for childhood immunisations.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice had access to transport services and had a low threshold for home visits where older patients could not access the practice. These were helping improve QOF exception reporting.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medicines. Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and nursing team worked with other health and care professionals to deliver a coordinated package of care.
- Practice staff communicated with a diabetes specialist nurse from the Royal Devon and Exeter hospital for advice and held an annual virtual ward with the hospital diabetic specialist consultant to discuss latest changes in diabetic care and to review patients with complex diabetes.
- Staff who were responsible for reviews of patients with long term conditions had received specific training and educational updates.
- GPs followed up patients who had received treatment in hospital or through Out of Hours services.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of medicines to lower cholesterol for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

Good

Are services effective?

- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- The practice nurse offered a lower limb ulceration enhanced care service and had treated six patients in the last six months for weekly or more frequently wound dressing and re bandaging following detailed doppler studies and wound assessment.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates in 2016/17 for the vaccines given were above the 90% national target (these ranged between 92% and 94%). The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Receptionists had received training and were aware of 'red flag' sepsis symptoms that might be reported by patients and knew how to escalate to a GP immediately if the symptoms were apparent.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 78%, which was slightly below the national 80% coverage target for the national screening programme but higher than the current 72% coverage achievement for the national screening programme. The staff recognised the uptake trends matched the lower national rates and were ensuring opportunistic health education took place. There were systems in place to follow up patients who did not attend screening appointments.
- The practices' uptake for breast and bowel cancer screening were in line the national average. For example, 71% of females between the ages of 50 and 70 had been screened for breast cancer in the last 36 months compared with the national average of 70%. Additionally 55% of patients between the ages of 60 and 69 had been screened for bowel cancer in last 30 months which compared to the national average of 55%.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- 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 held a register of patients living in vulnerable circumstances including homeless people, patients with addictions and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for monitoring and administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher than the national average of 84%.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive agreed care plan documented in the previous 12 months. This was higher than the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those

living with dementia. For example, 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was higher than the national average of 91%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, performing an audit of the domiciliary nursing visiting service.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, an application for funding for a Clinical Commissioning Group (CCG) pharmacist to assist with medicine management in the federation of GP practices.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role. For example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff said they had received mandatory training in the last 12 months via an eLearning resource. Spreadsheets were maintained to monitor this and reminders were included within staff meetings.
- Staff were encouraged and given opportunities to develop.
- Practice nurses had access to a programme of training and education for practice nurses and student nurses in the area. The practice nurse was a qualified Mentor after completing the Practice Nurse Mentorship Programme. She mentored post-registration nurses that were brand new to practice nursing whilst they were studying for their Foundations of General Practice Nursing qualification. She provided each student with up to 15 hours one to one time.
- The learning and development needs of staff were discussed at appraisal and on a more frequent and informal basis as required.
- The practice provided staff with ongoing support both formally and informally. This included an induction process, one-to-one meetings, appraisals, and support for revalidation. Staff spoken with told us they had received an appraisal and added that they felt supported within their roles. Staff stated that the open door approach of the GPs and practice manager helped with this supportive working atmosphere.
- The induction and development process for healthcare assistants (HCA) included the requirements of the Care Certificate. However, these had not been required as there had been no new HCAs employed since April 2015.
- The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. We received positive feedback from healthcare professionals who said the team at Whipton Surgery were friendly, professional and supportive.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community

services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that 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.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health such as through social schemes and voluntary services. For example, the practice referred patients to the carers group and voluntary services in the area. This included collaborative working with the 'drink wise age well' organisation who had visited the practice to provide an overview of the service and inform staff how they could refer patients and promote healthy living courses.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health such as stop smoking and tackling obesity campaigns.
- The Practice worked closely with Devon Drink Wise Age Well and examples of the practice innovative working was highlighted as a case study at Drink Wise Age Well's National Conference. The organisation had raised awareness with practice staff to provide an overview of the service and provided information on how patients could be referred and had been invited to host an information stand at recent flu clinics. During the Alcohol Awareness Week in 2017 and Healthier choices campaign in 2018text messages with information of what support was available were sent. Over 920 messages were sent each time. Promotion and advertising continue inside the practice with posters, leaflets and fliers of courses, activities and groups that DWAW are running.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Results of the July 2017 national GP patient survey, friends and family survey, in house survey, 60 CQC comment cards and interviews with patients were all positive about the staff group, access, care and treatment received. Comment cards contained lengthy and detailed positive feedback about staff, appointment access and the care and treatment recveived. There were no negative comments received.

Involvement in decisions about care and treatment

Patients told us staff helped and supported them to be involved in decisions about care and treatment. Staff were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

We spoke with six patients who told us they were 'delighted' 'lucky' and 'had no complaints' about the high standard of care they received. Patients said they felt informed in decision making processes and were empowered to suggest treatment options.

Privacy and dignity

The practice respected patients' privacy and dignity.

- 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.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. 94 (about 2.3%) carers were registered as 'carers' on the practice clinical system.

The practice staff ensured that patients were signposted to the Devon carers group, received written information and guidance of support services and were offered a carer health check.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as outstanding for providing responsive services .

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- During recent snowy weather staff had responded to the needs of the patients. This included staff walking over two miles in the snow to treat patients.
- Patients could book longer appointments to cover more than one issue per visit.
- Advance appointments up to six weeks in advance were available.
- There was an online appointment booking system. Patients registered to use this service could book appointments with a GP up to one month in advance.
- The facilities and premises were appropriate for the services delivered and had appropriate facilities for patients with reduced mobility.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

The practice had recognised that the patient population were situated in a geographical area which was identified as being more deprived. They acknowledged patients in the area were associated with poor compliance with health screening and higher rates of hospital admission and referral. As a result the clinical team had introduced several initiatives to improve continuity of care, compliance with health screening and treatment and reduce the need for patients to travel to secondary care for treatments. For example,

- Clinicians had introduced a domiciliary visiting nursing service for patients whose needs did not meet the criteria for the community nursing teams; but whose needs would benefit from early intervention. 82 home visits from the practice nurse in seven months had been completed to offer services including dressings, ECG (Heart tracing), urgent blood tests, vaccinations and injections, ear irrigation and long term condition monitoring. The nurse had been runner up in the local 2018 Practice nurse of the year award for this service.
- The practice nurse offered lower limb ulceration enhanced care following extended training. The team had treated six patients in the last six months for weekly or more frequent complex compression bandaging following a full assessment with a doppler study and wound assessment. This service had seen wounds healing between three and ten weeks and prevented patients travelling to the hospital for this treatment. Patients were able to fit the appointment in with other appointments at the practice. The practice nurse used these appointments to offer opportunistic screening and assess the overall health of patients. This service was over and above what was expected from the practice in the GP contract and had improved outcomes for patients.
- Reception staff (health navigators) had been trained to perform basic biometric measurements (Height, weight, BMI, blood pressure, near patient cholesterol checks and urinalysis) in the pop up clinics. This was introduced to capture information from patients who were likely to miss appointments or who did not require an appointment. The information gathered enabled the GPs to recall patients for further investigation or preventative treatments such as weight loss advice.
- The practice offered rooms to external health care professionals and services to enable patients easy and more familiar access to health care. These included mental health services, midwifery clinics and health visitor clinics.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice nurse had undertaken further training and education on end of life care.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were

Are services responsive to people's needs?

being appropriately met. Multiple conditions were reviewed at one appointment where possible, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- A home nebuliser service is provided by the practice to help patients retain their independence at home. This was used when a patient known to have respiratory disease had exacerbated symptoms and needed further help to breathe. The GP and practice nurse visited these patients at home and initiated nebuliser treatment. The GP and nurse wait to see effectiveness and give another dose if needed. If the patient stabilises, the nebuliser is left with them for three / four days to self-medicate until their symptoms have improved. In the last 12 months the GPs and Practice Nurse have made 23 visits to patients. The nebulising treatment offered in the patient's own home has meant that hospital admissions have been avoided.

Families, children and young people:

- 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- One of the GPs had expertise in community paediatrics which meant the GPs had expertise within the practice to refer to.
- Three of the GPs had expertise in women's health and child health which meant patients were able to access a full range of contraceptive services including emergency contraception. The practice nurse was trained in cervical screening and attended regular skills and knowledge updates.
- The practice took proactive steps to reverse the national downward trend of young adults not being screened for sexual health infections and cervical screening for women. Screening kits were available in toilets for patients to use. Sexually active patients were encouraged to be screened with increased uptake trend at the practice.
- The staff at Whipton Surgery had been working with another local GP practices to secure funding for two years for a Family Support Worker. The project began in 2017 with a focus of early intervention to prevent family and personal problems escalating and to combat the resulting strain on primary healthcare services. The Family Support Worker helped patients at the practice with parenting issues, housing issues, benefit and debt, social isolation and loneliness, domestic violence, substance misuse and general wellbeing. Since the project started 43 patients had been referred to the service and the practice had seen an 82% reduction in DNA's and attendance for routine appointments by these patients and their immediate family members. Patient feedback had been extremely positive and a case is being made for this service to be rolled out to all practices in Exeter when the pilot project funding ends in 2019.

Working age people (including those recently retired and students):

- The needs of this population group 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 opening hours, online services and text messaging services.
- One of the GPs had experience in offering occupational health checks for the local bus/coach company and was able to use this experience for patients. For example, assisting patients to return to work following accidents or injury.
- Travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available within the waiting areas.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, patients with drug and alcohol addictions and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia):

- Indicators for patients with poor mental health were higher than local and national rates. For example, the

Are services responsive to people's needs?

percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) was 100% compared with a local average of 85% and national average of 90%.

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher than the national average of 84%.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients who failed to attend were proactively followed up by a phone call from a GP.
- Patients with an enduring mental illness were offered an annual review with their preferred GP. A third sector organisation provided in-house psychological therapies at the practice.
- The practice worked closely with mental health services, counsellors, depression and anxiety services and advanced therapies for adults and children with poor mental health. These services were offered at the practice which was more convenient and familiar for the patient in distress.

The practice had recognised that patients at the practice were reluctant to engage fully with outside healthcare providers but had formed positive working relationships with staff at the practice. As a result the practice nurse has successfully completed a 12 month Macmillan 'Cancer as a long term condition: Developing Practice Nurse Skills' course. The nurse had knowledge of cancer as a disease and long term condition and its treatment and could support people with cancer to self-manage their health and lifestyle like those patients who had other chronic conditions. She had increased knowledge of the indicators of recurrence and what to do when indicators appeared and was aware of the resources available. The practice nurse had undertaken 39 cancer care reviews in the last 12 months.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis, and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use and added that they were pleased with the appointment service. Patients told us they could always get a same day appointment if necessary, request a telephone call or home visit. Parents and guardians said children were seen as a priority. Other patients told us they could always get an appointment on the same day or within a couple of days even if they chose a specific GP.
- Comprehensive information was available to patients about appointments on the website and within the practice. This included how to arrange urgent appointments and home visits and how to seek medical assistance when the practice was closed.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment were all consistently higher than local and national averages. For example,

- 83% of patients who responded said they could get through easily to the practice by phone; CCG – 82%; national average - 71%.
- 86% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 85%; national average – 75%.
- 85% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 84% and the national average of 80%.
- 87% of patients who responded described their experience of making an appointment as good; CCG - 82%; national average - 73%.

We spoke with six patients and received 60 comment cards whose views reflected these survey findings. Patients praised the reception team and said they went the extra mile to get appointments at a time convenient to the patient.

Since the last inspection the practice had monitored feedback from the annual patient satisfaction survey and had set up a pilot 'pop-in clinic' to address the length of time it took patients to get an appointment. The practice staff considered this would be most convenient for patients who needed flexibility due to their personal and work

Are services responsive to people's needs?

commitments. The pop in clinic was successful and continued to run. The practice was open between 8.30am and 6pm Monday, Tuesday, Thursday and Friday and between 8.30 and 12 midday on Wednesdays. Patients did not need an appointment to attend. All of the reception staff and administration staff had been trained to do blood pressures, cholesterol testing, height, weight and BMI (body mass index) monitoring and urine dip testing. We were informed that regular audits were conducted on the service and read that 158 patients had used the pop-in service in the last twelve months saving over 26 hours in appointment time. Patient feedback had been extremely positive and staff had reported an increased amount of job satisfaction as they had enjoyed the challenge of new learning skills whilst providing patients with a more accessible service. Staff added that they felt the service was far more personal and gave examples where they had picked up irregular readings that were referred onto the clinicians. Staff added that patients talked openly and the staff team have been able to signpost them onto other services or recommended they speak to their GP about their concerns.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment to patients who often did not engage with healthcare professionals.
- There had been no issues regarding the recruitment of GPs. Partners had previously been at the practice as salaried GP trainees and had chosen to return because of the leadership style and culture of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The culture developed at the practice was used to drive and improve the delivery of high-quality person-centred care.

- There was a low turnover of staff at the practice and GP recruitment had been successful. New GP partners had worked at the practice before, some during GP training.
- Staff stated they felt respected, supported and valued. They enjoyed and were proud to work in the practice.
- The practice staff focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff said there was support given when things went wrong and they were involved in the investigations. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff had received regular annual appraisals in the last year and said they had received informal support when the required and could request learning and development at any time. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff said their colleagues and leaders supported them both professionally and personally.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- Communication was effective at the practice and organised through structured, minuted meetings. These included partner meetings, staff meetings, multidisciplinary team meetings, notifications on the computer system and an open door policy used by the GPs and practice manager.
- Patients received a quarterly newsletter with updates on practice news, health promotion and staff changes.

Governance arrangements

Good

Are services well-led?

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were fully embedded, clearly set out, understood and effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of dealing with emergencies, safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints and communicated these effectively with the team.
- Education and clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was monitored and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The practice had attempted to get a face to face patient participation group formed but patients had been reluctant to engage. As a result the practice manager had formed a virtual group who were consulted about practice developments and changes. For example, changes in appointments.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. Staff said they were supported in their career development and education.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Good

Are services well-led?

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had been a research practice for 15 years and offered patients the chance to be participants in up to 10 research projects per year. Patients included in research studies could access potential treatment or resources not otherwise able to access. For example, additional blood tests currently only available in secondary care and discovering underlying pathology that wouldn't have ordinarily been discovered or been picked up during routine screening for research studies.
- Networking continued to be a priority of leaders and staff to deliver safe, effective, caring and well led service. For example, the practice manager was the LMC (Local medical council) pastoral support officer and director of finance for the Exeter Primary care federation and the practice nurse was a trainer and mentor for new practice nurses in association with Plymouth University. Positive feedback from these students was seen.
- The practice were continually looking at ways to develop and improve the service and had been part of several projects and pilots over the last two years. These included a social prescribing project, use of a family support worker and introduction of a Clinical Commissioning Group (CCG) pharmacist. The practice staff had been instrumental in obtaining funding for these projects.

Please refer to the Evidence Tables for further information.