Bideford Medical Centre

Quality Report

Abbotsham Road
Bideford,
Devon,
EX39 3AF
Tel: **01237 476363**
Website: www.bidefordmc.com

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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?	**Outstanding**
Are services well-led?	**Good**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Bideford Medical Centre on 25 November 2014. Overall the practice is rated as good. Specifically, we found the practice to be outstanding for providing responsive services. It was good for providing safe, effective, caring and well led services. It was good for providing services for all the population groups, noting that it was outstanding for providing responsive services for older people, children and young people, and people in vulnerable circumstances.

Our key findings were as follows:

- Outcomes for patients were positive, consistent and met expectations. Patients told us it was easy to get an appointment and a named GP or a GP of choice, which provided continuity of care. They confirmed they were seen or spoken with on the same day if they had an urgent need. All had an allocated GP.
- GPs kept individual lists so all patients had a named GP.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Reliable systems were in place to maintain safety throughout the practice.
- There was good IT support to enable staff to manage patient records well.
- Treatment rooms and public areas were clean and there were systems in place to ensure hygienic conditions and equipment.
- Continuity of care and good communication between parts of the practice and community staff was the key mark of this practice.

We saw several areas of outstanding practice including:

- The nurse practitioner ran a clinic for minor illness, for patients of all ages. Patients were able to book an appointment and be seen on the same day. This was

provided all day on Mondays and Fridays, and on Wednesday mornings. She found that anxious parents often brought their babies on Fridays, to get advice before the weekend.
- A pharmacy advisor was employed, funded for four hours by the CCG and eight hours per week by the practice in order to improve the service for patients. She said that if she found a patient's prescription was not appropriate for the patient she discussed it with their GP. She herself did not prescribe. She showed the patient different options such as blister packs and dosette boxes. These are boxes that patients can fill by themselves, or with assistance from family and carers. These have separate compartments for days of the week and / or times of day such as morning, afternoon and evening to help patients take their medicines accurately. The community matron and deputy contacted the pharmacy advisor when they encountered patients who needed support, for review of their medications or the method of delivery. They said she was a good resource and they consulted her for advice on queries also about patients who were registered at other practices. The pharmacy advisor told us that a new part of her job was to review discharge summaries from hospitals, especially of older frail patients, to identify potential mistakes or misunderstandings. She also checked that domiciliary care staff had been given clear instructions for example, whether eye drops were for the right or left eye.
- The practice recognised the challenge of communicating with teenagers. They had introduced a teen noticeboard, making changes to their web site and using twitter. They had been collaborating with other practices with the aim of reducing teenage pregnancies. They accommodated young patients who may have poor time keeping, with open type surgeries allowing them to be seen by a GP if they presented at reception, without much waiting or bureaucracy. They always booked in young patients when they asked, recognising their courage in coming to the practice. Patients came to the practice at 3.30pm after college, even if they were not registered there.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Provide training for staff in the Mental Capacity Act 2005 (MCA) and its relevance for their work in respect of patients who may lack capacity to give informed consent to care and treatment.

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.

Performance showed a good track record and steady improvements in safety. When anything had gone wrong, there was an appropriate, thorough review or investigation that involved all relevant staff. Lessons were learned and communicated to support improvement.

Medicines were stored safely. One GP took responsibility as prescribing lead. A pharmacy advisor was employed, four hours by the CCG and eight hours per week by the practice. She advised GPs about prescription practice and advised patients about delivery options such as blister packs and dosette boxes so they could see what might help them take their medicines accurately.

Policies and procedures were in place to maintain consistently good practice in cleanliness and infection control. Staff understood their responsibilities with respect to protecting children and safeguarding vulnerable adults. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Outcomes for patients were positive, consistent and met expectations. Health care professionals were pleased to tell us of the good relationships fostered between the teams. Health visitors said that from receptionists and cleaners throughout the team, communication was never an issue. They liked the continuity of care provided here and found the practice was family centred.

The pharmacy advisor told us that a new part of her job was to review discharge summaries from hospitals, especially of older frail patients, to identify potential mistakes or misunderstandings.

The staff were trained to use the intranet system where all required documents were stored. The IT manager was available to all staff and GPs, including attached staff such as health visitors if they were unsure of an IT process. Staff were pleased to praise him for his prompt help. He inducted all new members of staff, including GP registrars, on the IT infrastructure. Community staff had appropriate access to the message system. The IT manager also helped other local practices with IT system problems and was always available on the phone to help them out.

Summary of findings

Are services caring?

The practice is rated as good for providing caring services.

All the patients who spoke with us felt GPs, nurses and other staff were friendly, approachable and professional and they felt supported and well cared for. We observed patients being treated with dignity, respect and kindness during all interactions with staff. Patients making enquiries at the desk were dealt with respectfully, efficiently and professionally.

Patients said their GP had given very good in-depth explanations when they needed further treatment. Others said the GP got the right information for them, listened to them and their questions had been answered. Patients were involved and encouraged to be partners in their care and in making decisions, with any support they needed. Staff spent time talking to patients, and those close to them.

Good

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

The services were flexible, provided choice and ensured continuity of care. The GPs had individual lists, to promote continuity, and attached staff paid tribute to the focus on continuity of care within this practice. Community staff who spoke with us praised the practice for its excellent communication and the accessibility of the health care professionals.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, which provided continuity of care. They confirmed they were seen or spoken with on the same day if they had an urgent need. All had an allocated GP.

There was an effective duty system, enabling all patients who needed a same day appointment to see a health care professional. There was a high level of provision of appointments.

The nurse practitioner ran a clinic for minor illness, for patients of all ages. Patients were able to book an appointment and be seen on the same day.

They always booked in young patients when they asked. Patients came to the practice at 3.30pm after college, even if they were not registered there.

Single parents and frail elderly patients had been offered home visits in recognition of their difficulty in getting to the practice. Up to 12 home visits per day were made.

Outstanding

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services.

Staff knew and understood the vision, values and strategy. From a patient point of view the practice was working well and in keeping with their mission statement which was to deliver consistent quality of care to patients within available resources.

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns.

Staff told us the practice manager and senior nurses had been brilliant with supporting their training. Specific training was provided in accordance with individual needs and interests. The practice closed four afternoons per year. Sometimes these training sessions were opened up to other practices to attend, which was good for networking as well as promoting integrated working.

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.

Older patients all had a named GP. All those who spoke with us had been offered regular health checks. Each GP had a personal list of patients and a designated receptionist key worker who had a knowledge of the GP's registered patients. One GP had a diploma in palliative care, another had a diploma of geriatric medicine.

The practice had provided care plans for the 2% of their adult patients at most risk of admission to hospital, in accordance with the direct enhanced service (DES) commissioning scheme which mainly encompassed elderly patients. These patients could access their own GP and expect a same day consultation with a suitable health professional. As part of this service, patients were offered a review within 48 hours of their hospital discharge, their discharge summary having been reviewed within 24 hours of discharge notification from the hospital. All patients discharged from hospital were reviewed within 72 hours. Special messages were attached to the computerised patient records that Out of Hours services could see, to ensure consistent care. Patients with complex care needs were referred to the complex care team for additional support. In a crisis situation, access was made to a local Pathfinder team to organise rapid access to care at home, to try to avoid admission to hospital.

Regular weekly meetings with community matrons and hospice nurses were held. A monthly palliative care meeting was held involving the whole practice team, plus community matrons, hospice nurses and community nurses. Minutes kept of these meetings were of a high standard to support good care. There were good working relationships with the district nursing team which was co-located in the building. The practice responded to increasing frailty and made sure that a patient's dressings were changed if they failed to attend the clinic for this procedure.

A high rate of home visits were made, mostly to frail elderly patients. Reception staff booked appointments to coincide with bus times or phoned for taxis on behalf of patients if they needed this support.

A pharmacist was employed as a prescribing advisor, funded for four hours by the CCG and eight hours per week by the practice. She made home visits to see elderly patients who were struggling to

comply with medication to ensure concurrence. The prescribing advisor told us that a new part of her job was to review discharge summaries from hospitals, especially of older frail patients, to identify potential mistakes or misunderstandings.

Medication reviews were undertaken at least annually and medication reviews in the over 70s were categorised separately in the audit to ensure careful monitoring of these patients.

GPs were responsible for patients in community beds in the local community hospital and provided medical cover to a local nursing home with a regular clinic on site at the home.

People with long term conditions

Good

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

A full range of nurse- led chronic disease clinics were provided, all of these were overseen by a GP responsible for the condition. There was a recall system to ensure patients' health was monitored regularly. The medicines management team carried out medication reviews to ensure quality of care. All patients had a named GP.

When appropriate, for example for a patient with COPD, 'rescue' medication is provided for patients at home. COPD and asthma patients including children were encouraged to have an escalation plan. Special messages were attached to the computerised patient records that Out of Hours services could see, to ensure consistent care. If a patient was admitted to hospital, the practice sent an 'emergency letter' to the hospital with details of both the current problem and of past medical history including current medication and allergies to enable consistency of care.

When necessary, home visits were made by GPs or community nurses to carry out reviews.

We offer extended hours appointments to allow access to working age patients with chronic disease

The nursing team had regular clinical updates and attended courses to keep their skills up to date. The prescribing advisor worked with the nurses to support patients with chronic conditions who needed complex medical advice.

Families, children and young people

Good

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

The midwifery team, health visiting team and school nurses, though not employed by the practice, were co-located in the building to

ease communication. Attached staff who spoke with us commended the practice for its focus on good communication and continuity of care. Any non-attendees at post-natal checks were highlighted to the health visitors. Post-natal checks were booked on the same day as first baby immunisations to allow easier access for new parents. Health visitors praised the care and attention given, for example, if they asked for help for a mother with post natal depression, or a baby with special needs, it was provided promptly. They felt their expertise was valued.

There was a small children's play area in the waiting room with games and books, which was kept clean on a daily basis. Reception staff highlighted any telephone calls from parents or any children in the waiting room who give cause for concern, to the duty GP or their registered GP. Duty GPs saw on the day any child that parents were concerned about. Receptionists highlighted issues related to pregnancy as urgent to the duty team. Midwives also talked to GPs or left messages on GPs' screens about any concerns. Antenatal appointments could be made up to eight weeks ahead.

To meet increasing demand and offer more flexibility to parents, in the last six months, the practice introduced an extra baby immunisation clinic each week. Thursday morning clinic was predominantly for babies and Monday afternoons for pre-school and some babies. Nurses are also offer immunisations to babies and children in the usual treatment room appointment slots if that were more convenient for the parents/guardians.

There was no specific age limit for unaccompanied consultations for children. The practice policy was that if a young person felt comfortable attending by themselves they would be seen but they would be encouraged to discuss their consultation with a suitable adult. Staff described their understanding of Gillick competence, that is the child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, depending on the child's maturity and understanding and the nature of the consent required.

The personal list system meant the practice had a good knowledge of vulnerable families and they had identified children in families who may have a carer role. The reception team checked immunisation attendance and highlighted to GPs when a family of concern did not attend for immunisations. Our minor injury unit (MIU) informed the GP of children who were frequently brought for treatment and asked for immediate attention if concerned about a child.

Quarterly safeguarding meetings were held, involving GPs, health visitors and school nurses. All children's safeguarding concerns were

considered. Staff would share concerns between meetings if necessary, with shared access to the computer records. Warning messages were attached to the computer records of all immediate family members of a child 'at risk' or 'a cause for concern' to ensure all staff were aware when seeing them.

The practice recognised the challenge of communicating with teenagers. They had introduced a teen noticeboard, making changes to their web site and using twitter. They had been collaborating with other practices with the aim of reducing teenage pregnancies. They accommodated young patients who may have poor time keeping, with open type surgeries allowing them to be seen by a GP if they presented at reception, without much waiting or bureaucracy. They always booked in young patients when they asked, recognising their courage in coming to the practice. Patients came to the practice at 3.30pm after college, even if they were not registered there.

Working age people (including those recently retired and students)

Good

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

NHS health checks were provided, mainly for working age patients. The practice website details all clinics available, including stop-smoking, in addition to providing access to health promotion advice and travel advice. Weight management clinics are also provided.

Early morning and late evening appointments were offered, to allow easier access to working patients. Patients could book with a GP up to four weeks in advance to allow them the chance to fit an appointment around their work schedule. Appointments with nurses, health care assistants and the midwifery team could be made up to eight weeks in advance.

Telephone appointments with GPs were available, either booked or for urgent advice, to further improve access and offer flexibility. Patients could order prescriptions on-line and an increasing number of patients, mainly working patients, email individual doctors for advice.

People whose circumstances may make them vulnerable

Good

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

Homeless patients were treated as temporary patients and their address recorded as the practice's address. Appropriate systems and knowledge is in place especially in the reception area. The practice knew of a number of homeless patients and also many patients who lived at a local holiday camp who could not receive mail direct.

Summary of findings

These patients were able to use the practice address as a 'care of' address for hospital appointments. Staff told us of a homeless patient who visited the practice on the day of this inspection for dressings to be changed. Staff found they had been able to provide good continuity of care.

When patients had insufficient funds to ring to book appointments at the hospital or ring the Devon Referral Support Service (DRSS) after being referred, staff had accessed the booking system for them and arranged their appointments. The practice registered with the local food bank and GPs could issue food vouchers directly to patients and refer patients to appropriate support services.

The practice recognised communication with patients with a learning disability as a challenge. These patients were offered annual extended health checks with a pre-appointment questionnaire being sent to them, compiled as a combination between diagrams and 'easy read' format, to help them prepare.

Three GPs had undertaken Drug and Alcohol Shared Care training and were in the process of taking the responsibility of Shared Care for methadone prescribing for a small number of stable patients each. They had acted as advocate for patients in difficult circumstances. Staff told us that intravenous drug users came into the practice if they had infected sites and staff took these opportunities to offer health care and support. Patients had also been referred to the drug and alcohol service Adaction, who gave social support.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people with poor mental health.

A GP took responsibility as lead for mental health. Extended annual health checks were offered to patients on the severe mental health illness register and dementia register. Health care assistant took blood tests to check functioning of kidneys, liver, cholesterol and sugar levels. If they were prescribed lithium, their blood pressure and weight would be checked. Then they attended their care review with their GP, who would contact them later if necessary about the results of the blood test. Registered carers were also invited for health checks.

Administrative staff checked the records and recalled patients at the appropriate time. If patients did not attend, reminders would be sent three times. If they still failed to attend, staff informed their GP.

Summary of findings

At this half way stage of the year, mental health reviews had been done for 37% of patients, and dementia reviews for 23% of their group of patient population. Patients attending chronic disease clinics were screened for depression.

GPs could refer patients to a memory clinic. They kept a register of patients with dementia which showed a lower than expected number of patients recorded. GPs told us they considered this to result from a failure to add the correct code to the computerised records, rather than a failure to identify individuals' problems.

Nurses administered depot anti-psychotic medication as prescribed and liaised directly with either the GP or the patient's psychiatric nurse or their key worker if they fail to attend. The prescribing team provided daily and weekly prescriptions as needed and the community pharmacists liaised with them if scripts were not collected.

The adult and older adult psychiatric teams were invited several times a year to lunchtime meetings to update on services. Community psychiatric nurses were invited to join the regular informal mid-morning meetings.

Summary of findings

What people who use the service say

During the inspection we met with 15 patients and observed staff interactions. All felt GPs, nurses and other staff were friendly, approachable and professional. All those elderly patients interviewed had been offered regular health checks. All felt that the practice was of a high standard, staff were friendly and approachable, and the building modern, clean and welcoming.

None of those interviewed had any serious complaints regarding the practice. Patients praised the continuity, having had the same named GP in some cases throughout their life.

Waiting times were acceptable, generally no more than 15 minutes. Patients said they did not feel rushed during their consultations.

Patients told us they had a good rapport with their GP and felt no improvements were needed. They said GPs always phoned back when they said they would.

Patients said they could get appointments when they needed. Some said they liked being called to their appointment by the screen. One person said they would like later evening opening hours.

One parent said it was not easy for their children to play in the waiting area, but this had not been a problem because they had not had to wait long.

We received 60 CQC comment cards that had been completed by patients at the practice.

Respondents said the nurses and GPs were very caring and they had received an excellent service. One patient said they had received first class treatment at all times including when they were really unwell and needed advice and an emergency appointment. Others said they had been able to get an appointment on the same day for themselves or their child.

Patients said their GP always listened to what they had to say. They said most staff were polite and efficient and treated patients with utmost dignity and respect. They were more than helpful and did everything they could to help. One person said they could never have coped without their GP's help and support.

Patients said their GP had given very good in-depth explanations when they needed further treatment. Others said the GP got the right information for them, listened to them and their questions had been answered. One said they were extremely lucky to have been fortunate enough to have a GP who made them feel at ease so they were not at all embarrassed to talk about their medical problems.

Patients said that inside the practice it was always clean, tidy and hygienic.

There was an active Patient Representative Group (PPG) which had been running for four years and met every four months. They assisted with promoting the centre.

We spoke with two PPG members. They told us a GP and manager came to their meetings. The practice manager provided the agenda. Topics discussed had included facilities for patients and telephone access. They have been able to accommodate our request for longer appointments.

One PPG member had assisted in childhood development clinic. Another member of the PPG had led the fundraising for equipment for the practice, for example, an automated external defibrillator (AED). An AED is a device used to restart a patient's heart after a cardiac arrest

PPG members said that meetings were used for disseminating information from the practice in addition to consulting on their views. They were keen to promote the practice, to improve facilities for patients and carers.

Areas for improvement

Summary of findings

Action the service SHOULD take to improve

- Provide training for staff in the Mental Capacity Act 2005 (MCA) and its relevance for their work in respect of patients who may lack capacity to give informed consent to care and treatment.

Outstanding practice

- The nurse practitioner ran a clinic for minor illness for patients of all ages to be booked on the day to enable patients to be seen on the same day. This was provided all day on Mondays and Fridays, and on Wednesday mornings. She found that anxious parents often brought their babies on Fridays, to get advice before the weekend.
- A pharmacy advisor was employed, funded for four hours by the CCG and eight hours per week by the practice. She said that if she found a patient's prescription was not appropriate for the patient she discussed it with their GP. She herself did not prescribe. She showed the patient different options such as blister packs and dosette boxes. These are boxes that patients can fill by themselves, or with assistance from family and carers. These have separate compartments for days of the week and / or times of day such as morning, afternoon and evening to help patients take their medicines accurately. The community matron and deputy contacted the pharmacy advisor when they encountered patients who needed support, for review of their medications or the method of delivery. They said she was a good resource and they consulted her for advice on queries also about patients who were registered at other practices. The pharmacy advisor told us that a new part of her job was to review discharge summaries from hospitals, especially of older frail patients, to identify potential mistakes or misunderstandings. She also checked that domiciliary care staff had been given clear instructions for example, whether eye drops were for the right or left eye.
- The practice recognised the challenge of communicating with teenagers. They had introduced a teen noticeboard, making changes to their web site and using twitter. They had been collaborating with other practices with the aim of reducing teenage pregnancies. They accommodated young patients who may have poor time keeping, with open type surgeries allowing them to be seen by a GP if they presented at reception, without much waiting or bureaucracy. They always booked in young patients when they asked, recognising their courage in coming to the practice. Patients came to the practice at 3.30pm after college, even if they were not registered there.

Bideford Medical Centre

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 advisor, a practice manager and an Expert by Experience (this is a person who has personal experience of using or caring for someone who uses this type of service).

Background to Bideford Medical Centre

Bideford Medical Centre is based close to Bideford town centre, beside the hospital.

Around 15,000 patients are registered with this practice. There is a higher than average proportion of older patients and low representation of ethnic minorities. The practice recognises teenage health issues and drug and alcohol problems as a challenge.

There are 10 GP partners, three women and seven men; three salaried GPs, two are women and a full time GP registrar. Not all are employed full time, the 14 GPs represent a full time equivalent (FTE) of 10.62.

A part time nurse practitioner is employed and six practice nurses, totalling FTE 4.32 plus seven health care assistants totalling 3.36 FTE. A team of administrative staff with a variety of skills and qualifications are employed.

This is a training practice. Two GPs are trainers, and another is a GP educationalist and mentors registrars at the practice.

The partners are planning for succession, expecting to expand the group of partners and capacity for providing health promotion. The number of patients registered with the practice has been continually increasing, partly due to house building in the area. At the time of this inspection 2,500 houses were being built including two extra care housing schemes. The practice has responded by appointing a salaried GP for an additional two sessions, agreeing to work collaboratively with other local practices. They were working on plans to add to their premises.

This is the first inspection at Bideford Medical Centre. The CQC intelligent monitoring placed the practice in band 2. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The problems that led to the practice being placed in band 2 included a failure to meet targets for providing influenza immunisation to patients with diabetes. In the year to 31 March 2014 there had been a shortage of the flu vaccine and they had not achieved their target. This year they had improved uptake by 2%.

Another problem identified by the banding report was the percentage of patients with atrial fibrillation who were being treated with anti-coagulant therapy. The practice informed us that the IT manager had done a re-audit and found these figures had improved. Patients had been invited for an electrocardiogram (ECG) to check whether they were still in AF. In response to information in the banding report, the practice informed us there had been considerable amount of sickness in the treatment room staff group last year, and there had been difficulty in

employing locum nurses. They were training health care assistants (HCAs) and, for example, had upskilled them to be able to carry out diabetic monitoring. The HCA checked and recorded the patient's blood pressure, weight, ABPI, and neuropathy, then the practice nurse advised on the treatment required.

Advice is given to patients who need medical help when the practice is closed, to call 111 for Devon Doctors.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 November 2014.

During our visit we spoke with a range of health care professionals and administrative staff and spoke with patients who used the service including members of the patient participation group (PPG). We also talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led
- We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 November 2014. During our visit we spoke with a range of staff and GPs and spoke with patients. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. The practice manager forwarded national patient safety alerts to partners and other appropriate staff. The practice employed a prescribing advisor who considered alerts about medicines and sent them to appropriate staff such as the prescribing nurse. If action was needed, this was highlighted and reviewed at the next practice meeting. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Updates of guidance on best practice were made available on an intranet service where the practice's policies were displayed.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the past two years. This showed the practice had managed these consistently, showing evidence of a safe track record and a system for monitoring action taken in response to alerts.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year. Quarterly meetings were held to discuss significant event analysis (SEA). Staff involved in an incident were specifically invited to SEA meetings, whether nurses, receptionists or whatever their role. Health Visitors told us they may go if their patients were affected. The events were discussed, actions agreed and learning points documented. Actions from previous meeting were also discussed, with a review of action that had been taken. For example, a baby had been given a vaccination which did not contain all the elements prescribed, so had to have a second injection. The packets had been changed, leading to staff not recognising the difference. The practice contacted the CCG and the practice nurse forum with their learning, to share the potential risk due to changed packaging. This showed the practice was open and keen to share information to protect patients.

Staff were aware of significant events that had been recorded. Staff told us they had been involved when appropriate and that action to follow was posted on the intranet. Staff looked at this out of professional interest. Staff told us about the open nature of these meetings. They sat in a circle and all team members, whatever their role, brought their mistakes to be shared and learned from. If there were none to be discussed, they fed back on training they had attended.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures were in place with respect to children and vulnerable adults and reviewed annually. The management team were aware of their responsibility to report any safeguarding issues to the CQC.

Staff took a proactive approach to safeguarding, focussing on early identification. They took steps to prevent abuse from occurring, responding appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. A system was in place to code children's computerised records if they were on the at risk register so that an alert showed on the screen whenever a clinician opened the patient's records. Multi-disciplinary safeguarding children meetings were held quarterly where safeguarding issues and reports were discussed. Health Visitors attached to the practice told us they found these meetings to be effective. They said that issues were discussed informally, with good communication between themselves and the GP team. They provided 'pop-ups' for the GP patient records so that when a family with problems came for a GP consultation, the GP would be alerted to any family issues. When a Child Protection alert was raised, the GP wrote a report, for example about the health of the mother or other factor affecting the well-being of the child. Health visitors said that part of the area in which they worked had high rates of deprivation, so they provided background information to the meeting about the difficulties and disruption in some families' lives.

A GP was lead for adult safeguarding and another for child protection. They had achieved level three in training.. Not all the other GPs had achieved this level, but they were working towards it.

Staff had engaged in training in-house for child protection and safeguarding vulnerable adults. There had been a lunchtime educational meeting about safeguarding and have also had input at practice nurse meetings, but not certified training. They had been given scenarios in this training so they could see the relevance to their roles. They

had been trained to be aware of potential threats, including terrorism. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They knew that patients with learning disabilities were vulnerable in the community, including domestic abuse. They knew what to do if they had concerns and knew that the contact details for the multi-agency safeguarding hub (MASH) were available on the practice's intranet. A staff member from MASH had come to the practice to give a talk to staff.

The GP lead for mental health told us that all GPs and staff were aware of issues around patients' capacity to give informed consent to treatment. They told us about best interest meetings that they had been involved in and contributed to.

A chaperone service was offered, which was displayed on a small sign behind the reception desk and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Reception staff said they were generally alert to patients needing the service and would offer it accordingly. All nursing staff, including health care assistants, had been trained to be a chaperone. A small number of reception staff would act as a chaperone if nursing staff were not available. These receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. A robust chaperone policy was in place and a chart was available showing which staff had been trained and could take responsibility for chaperoning.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. The plugs for the fridges were labelled, to instruct staff not to unplug them.

Processes were in place to check medicines were within their expiry date and suitable for use. No controlled drugs were kept. The contents of the fridge were recorded and weekly checks showed that staff ensured no medicines were kept beyond their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Public health had done an annual check of the vaccinations, and the practice nurses had updated their own checks.

Patients told us they were pleased with the ease and accuracy of the repeat prescription service. Prescriptions were easily accessible by completing forms at the surgery and collecting medicines from a designated pharmacy. When one patient found a mistake had occurred, the receptionist checked the computer records to determine the cause and the matter was rectified quickly, politely and with courtesy, valuing the patient and a satisfactory outcome.

Patients told us their GP had explained the possible side effects of medicines they prescribed. Few had received leaflets with the medication but relied on instructions on the actual medication box or bottle provided by the pharmacy.

One GP took the responsibility as prescribing lead. Administrative staff were given a definite process to follow for repeat prescriptions and knew when to bring to the attention of the GP for example, if a request did not arrive within the expected time. The GP would then review the patient's care. The nurse prescriber could authorise repeat prescriptions within her competence, for example emollients. She checked with the GP for prescriptions, for example, for eye drops, to ensure safe practice.

A pharmacy advisor was employed, four hours by the CCG and eight hours per week by the practice. Her role included making home visits when GPs thought this would improve matters for patients. This could be when there were concerns that patients were not understanding their medicines, or frequently running out, or other issues such as families introducing dosette boxes without consulting the patient. The advisor said that if she found the prescription was not the best that would work for the patient she discussed it with their GP. She herself did not prescribe. She showed the patient different options such as blister packs and dosette boxes so they could see what might help them take their medicines accurately. She did not change any prescription.

The community matron and deputy contacted the pharmacy advisor when they encountered patients who needed support, for review of their medications or the method of delivery. They said she was a good resource and

Good

Are services safe?

they consulted her for advice on queries about patients who are registered at other practices. The community matron told us they were working jointly with the prescribing advisor on a telecare product, which may help some patients manage their medicines more reliably. They consulted to ensure they were doing all they could.

Cleanliness and infection control

The nurse practitioner had been given responsibility as lead for infection prevention and control (IPC). The practice had an IPC policy that had been reviewed annually to ensure it was kept in line with current guidance. There were associated policies for hand hygiene, decontamination of reusable equipment, and personal protective equipment (PPE) such as gloves and aprons. PPE and paper roll to cover the couches were provided in wall mounted dispensers close to where staff needed them to provide care and treatment. Masks and goggles that nurses used, for example when syringing ears, were also provided.

Training on IPC had been provided in-house during lunchtime sessions, and a session with a speaker from the local district general hospital had been arranged.

In the treatment room the work benches were clear and clean. The curtains provided round the couch for privacy were dated 20 November 2014 showing they had been renewed three days before our visit. The practice policy required them to be changed at six monthly intervals, or when visibly dirty. Paper on the couch was replaced between each patient.

We observed the premises to be clean and tidy. Staff said they cleaned surfaces with disinfectant wipes. The treatment rooms and recovery room were without carpet and had easily cleanable flooring. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Hand gel was kept by the automatic check-in at reception, but we saw few patients using it and there was no sign indicating what it was for.

There was a protocol for safe disposal of sharp instruments following minor surgery. Instruments were all sent off to the central sterilisation service at the local hospital to be sterilised for reuse. Each item was dated and signed for, recorded in a book with bar codes so if necessary it could be traced back to the patient. Sharps accidents had been reviewed by nurses, and there not been any recently.

Audits had been introduced. We saw there were cleaning schedules in place and cleaning records were kept. Every surface was checked and cleaned at the beginning and end of each session, recorded and signed for accountability. A nurse practitioner had recently carried out a hand washing audit with staff, using a light box to demonstrate any shortfalls in cleanliness. GPs had carried out six monthly audits of infection rates following minor surgery to assure themselves their practice was safe.

We saw that toxic waste, clinical waste and sharps were stored safely and disposed of legally. We saw the certificate showing that the water tanks had been disinfected and the regular checks of shower heads and sinks and water temperatures throughout the system had been maintained and recorded to ensure continued safety from Legionella.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, oximeters, spirometers, blood pressure measuring devices and the fridge thermometers.

The prescribing advisor was able to introduce devices that patients might find helpful. For example, a diabetic testing machine. She made a computer search for patients involved and contacted them, then made home visits to patients to demonstrate new equipment on request, at the expense of the supplier.

Staffing and recruitment

The practice had a suitable and clear recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment including proof of qualification and registration with the appropriate professional body. We saw the full list of criminal records checks and reference numbers through the Disclosure and Barring Service (DBS) that had been carried out in respect of all GPs, nurses and those administrative staff who carried out chaperone duties

Good

Are services safe?

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

There was a fire risk assessment in place which had been drawn up by a Fire Officer in consultation with the practice manager. They checked the fire exit doors and confirmed all were in good order. The fire alarm system had been maintained professionally and checked weekly by staff. There was a system in place that ensured fire extinguishers were checked regularly. Staff had received annual fire safety training, including staff that used the lower ground floor although they were not employed by the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. A nurse checked the resuscitation equipment weekly. All equipment and adrenaline were in date and recorded on a chart. Equipment was available to help adults and children who were having difficulty breathing.

Oxygen cylinders were provided in the minor operations room and the treatment room.

Every staff member with access to a computer screen could request immediate assistance. This function was used if a patient collapsed or who otherwise became acutely unwell. By requesting immediate assistance an alert goes to all logged-on users of the clinical system and their screens would flash. The alert details who requested help and their location. Examples of use would be, for an acutely sick child – for example recently a parent brought three sick young children for an appointment. The GP requested assistance. Another recent example was when help was requested after a person collapsed in the local pharmacy.

Risks to safety from service developments, anticipated changes in demand and disruption were being assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations. A robust business continuity plan was in place. This covered the range of anticipated emergencies, assessed their potential impact and assigned responsibility to staff for alerting others and preventing escalation. This covered breakdown of systems including computers, adverse weather including flooding. Arrangements were in place to arrival of an infected or contaminated patient as well as a strategy to act in the event of a pandemic perhaps in collaboration with other neighbouring practices and/or the CCG and Public Health England. Clear instructions for staff had been prepared and useful contact details listed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us that when they went for consultations the GP was aware of their medical history and that they had enough time with the GP. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This includes during assessment, diagnosis, when patients were referred to other services and when managing patients' chronic or long-term conditions, including for people in the last 12 months of their life. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. There is an active consultation network within secondary care which the practice GPs used for advice.

There was a robust system in place to register patients in need of palliative care. There was a register in place in accordance with the Gold Standards Framework, which enables staff to provide good quality care by advance care planning. A structured palliative care meeting took place monthly between the GPs, practice manager, district nursing staff and local cancer care nursing staff. The meetings were documented and records kept of these meetings were of a high standard to support good care.

Meetings with the community matron were held every two months for patients in danger of admission to hospital, to discuss what could be done to reduce the risk. Each patient had a named GP and care plan. The 3% considered most at risk were case managed, some by GPs and some by the community matron and district nurses. All staff who were involved with these meetings paid tribute to the good communications within this practice which enabled good practice. Home visit reports were shared when appropriate and the helpfulness of administrative staff was appreciated. GPs visited patients in care homes. When patients were admitted to hospital, this was discussed by the GPs at their Friday meeting. Any unplanned admission was reviewed at the monthly team meeting. GPs updated their care plans on the patients clinical notes and care plans were transferred to the Out of Hours service via the IT system (Adastra) to maintain continuity of care.

Systems were in place to assess risks in newly registered patients. Administrative staff arranged health care reviews for patients with learning disabilities or long term conditions. There was a system to make sure no-one was missed and if patients failed to arrive staff phoned or wrote to them to make an appointment. Patients were invited for a NHS health check which included advising them of what they were entitled to.

Information from the quality outcomes framework (QOF) showed that regular health assessments had been carried out in line with the national average. For example, the expected proportion of patients with schizophrenia or other psychoses had an agreed care plan documented in the previous 12 months and the percentage of women between the ages of 25 and 65 whose notes record that a cervical screening test had been performed in the preceding 5 years. The percentage of patients with atrial fibrillation, measured within the last 12 months, who were being treated with anti-coagulation drug therapy or an anti-platelet therapy was well below what was expected, and recorded as an elevated risk. GPs told us that staff absence during the previous year contributed to this shortfall and that it had been addressed. The up to date QOF screen shot confirmed this achievement.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored. This included assessments, diagnoses, referrals to other services and the management of people with chronic or long-term conditions. This information was used to improve care. Outcomes for patients were positive, consistent and met expectations.

A GP took responsibility as the QOF lead for the practice. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The GP lead monitored the QOF closely and led on the fortnightly meetings which took place to discuss changes and improvements on recording

Good

Are services effective?

(for example, treatment is effective)

the patient data. Templates had been adjusted or created according to the requirements of the disease register requirements. The up to date QOF achievement screen shot showed that targets had been met.

The administration team were responsible for scanning letters on to patient records. This process was done the same day that the letter arrived at the practice. The transfer of test results via the clinical system took place daily and the results were electronically forwarded to the health care professional who requested the test. The GP or nurse reviewed the results in a timely manner. If they were away a buddy clinician would view the results. Administrative staff carried out monthly searches of the clinical system and informed the GP if any reviews were outstanding, for example, to ensure that osteoporosis specific fractures were reviewed.

Clinics had templates for staff to follow as well as a written protocol to ensure the health assessment was comprehensive. For example, when a patient with hypertension attended for their check-up, the template showed that staff checked with them about their smoking and alcohol consumption and checked their blood pressure, weight, pulse and took a blood test. If there were signs of fibrillation the nurse booked an ECG test for the patient. The computer programme allowed staff to book a recall in six months, ensuring a letter would be sent.

Another nurse showed us the template for leg ulcer assessment, at two, six and 12 weeks. It required the nurse to assess nutritional status, take blood tests and repeat the ankle brachial pressure index (ABPI). There was an effective new doppler machine which gave a reading within five minutes, to check blood flow in the large arteries and veins and define a safe level of compression bandaging.

The practice had a system in place for completing clinical audit cycles. The pharmacy advisor organised the audits required by the CCG, gathered data and presented it to the GPs. Examples included the pregablin (a medicine prescribed for pain) audit for the practice. GPs provided their records to the pharmacy advisor for collation and the results were discussed by the team and submitted to the CCG.

Audits had been done for the benefit of patients as well as meeting QOF requirements. A range of audits that had been reviewed. For example, an audit was carried out about leg ulcer dressings, led by GP, to ensure patients were receiving optimum treatment options, based on assessment through blood tests and Doppler tests.

Doctors in the surgery undertake minor surgical procedures in line with their registration and NICE guidance. The staff are appropriately trained and keep up to date. They also regularly carry out clinical audits on their results and use that in their learning.

GPs who carried out minor surgery had slightly reduced lists. Friday was surgical day, mostly for vasectomies, carpel tunnel, moles and skin lesions. Referrals are taken from across NEW Devon CCG area, not only for patients registered at this practice. Six monthly audits were carried out by GPs to evaluate carpel tunnel and vasectomy procedures that had been carried out as well as a patient satisfaction survey. These were reviewed within the practice, sent to the 22 practices in the locality and the CCG. 98% of patients expressed satisfaction with process, 90% with the GP's explanation, and there had been low complication rates.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. There were nurses with extended roles seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease. They were also able to demonstrate that they had appropriate training to fulfil these roles. Nursing staff had also received specific training to update skills, such as taking smear tests and syringing ears.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

There was a very good provision of appointments, currently 126 appointments weekly per full time GP. There were established triggers for appointing locums, to maintain the level of provision. Nurses worked with managers to deploy staff effectively. They tried not to get behind with clinics,

Good

Are services effective?

(for example, treatment is effective)

but did not always have the resources and asked managers for help if support was needed. When retirement was imminent, succession planning had been discussed with partners.

Working with colleagues and other services

Staff, teams and services are committed to working collaboratively, people who have complex needs are supported to receive coordinated care and there are innovative and efficient ways to deliver more joined-up care to people who use services. The practice was working ever closer with other practices in the area. They were changing to a new system in line with other practices (currently 15) to improve co-operative working.

The practice supported the Minor Injury Unit at the adjacent hospital. The duty GP attended for daily clinics. The GPs provided emergency cover for the stroke unit in the hospital and provided emergency cover for patients if other consultants were not available as well as caring for their own patients in GP beds within the hospital. MIU nurses contacted this practice when patients had gone to them for medical advice and treatment. This showed that the practice was flexible in providing care for patients wherever they presented with their request for help.

Nurses who worked in the practice told us they found it easy to communicate with GPs, having coffee together daily and lunchtime meetings every Monday and Friday. Nurses who were community based told us they worked closely with the GPs including some patients with very complex needs. They appreciated that the GPs respected their judgment and made home visits when asked. The nurses said the GPs did not object to interruptions - if they needed advice urgently, they waited outside consultation rooms, went in between GP patient appointments to discuss a case and receive advice.

The practice let out rooms on the lower ground floor to health visitors, school nurses, nursery nurses and district nurses. All those we spoke with were pleased to tell us of the good relationships fostered between the teams. Health visitors said that from receptionists and cleaners throughout the team, communication was never an issue. They liked the continuity of care provided here. The practice was family centred. For example, when there were children in the family, the GPs let us know when the mother is ill. They appreciated that a GP came down in person to tell them when there was a sudden death of a member of a family they were working with. They said they could not pick out individuals for praise. The younger GPs had taken on the values of the retired GPs and insisted on good continuity of care and respect for the other professionals. GPs also said they enjoyed good working relationships with other teams, including midwives, health visitors, the community mental health team and palliative care nurses.

There was a typing team who were responsible for typing referral letters in a timely manner.

The referrals were created by the GP on the Choose & Book System and patients were given a choice of hospitals to attend. The referrals were created in a timely manner once the referral had been created by the GP and the patient had received the print out instructing them how to book the appointment direct with the hospital. If a patients was anxious because they had not heard about their referral, administrative staff phoned the hospital to chase it up.

The pharmacy advisor told us that a new part of her job was to review discharge summaries from hospitals, especially of older frail patients. The GP informed her when patients were admitted to hospital. She visited the patient at home when the discharge summary had arrived. She gave us an example of when this had been helpful to avert a potential mistake. A patient had been to a regional hospital where a different medicine had been prescribed. The consultant sent a letter saying they wanted the situation (with regards to medication) to be on-going. The prescribing advisor found this had not been actioned, as it was not a discharge summary, so she ensured that the GP was aware.

Information sharing

The systems to manage and share the information that was needed to deliver effective care were coordinated across services and support integrated care for people who use services. The practice predominantly used paperless records and all of the staff were trained to use the intranet system where all required documents were stored. The IT manager was available to all staff and GPs, including attached staff such as health visitors if they were unsure of an IT process. Staff were pleased to praise him for his prompt help. He inducted all new members of staff, including GP registrars, on the IT infrastructure. The IT manager also helped other local practices with IT system problems and was always available on the phone to help them out.

Good

Are services effective?

(for example, treatment is effective)

Community staff had appropriate access to the message system. Staff within the practice entered messages, or set up a screen so community staff could type in a message and share knowledge appropriately. A system for secure remote access to the computer was available for GPs and the IT manager when they were not at the surgery.

Consent to care and treatment

The GP who was lead for mental health problems had knowledge and experience of working with patients when there were issues about their capacity to make informed decisions about their own care and treatment. Other staff had not benefitted from training in the Mental Capacity Act 2005 and its relevance for their work in respect of patients who may lack capacity to give informed consent to care and treatment.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing, with the support of their carer. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. The community matron told us that her team checked that GPs got the patient's consent when being referred to the complex care team.

Any advance plan including an instruction that the patient should not be resuscitated in the event of a cardiac arrest was investigated appropriately either by a visit or by contacting the carer or next of kin who was recorded on the patient records.

We found staff using their understanding of Gillick competence, that is the child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, depending on the child's maturity and understanding and the nature of the consent required. For example, if a patient under 16 years was requesting contraception, the nurse practitioner asked safety questions to assure herself that the sexual relations were consensual, and advised discussion with their families. Her experience was that young patients did come back, taking responsibility for their decisions.

Health promotion and prevention

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was used to do so. Nursing staff told us that when patients came for their medication reviews, they checked each patient's weight, height and took a blood test.

All those elderly patients interviewed had been offered regular health checks. Patients told us there was an abundance of health information on display boards in the waiting areas, plus information screens. There were posters in the reception area promoting "Merry Quitmas" for smoking cessation. All health care professionals promoted smoking cessation during consultations and recorded current smoking status when required. There was a TV screen in the reception area that promoted smoking cessation and healthy lifestyles.

The practice had taken on responsibility for the weight management service, accepting patients from other practices through a hub. Nursing staff told us of a weight management course they offered, called 'Journey of change'. This had involved two days of training including university input. They gave dietary advice, and counselling to inspire and support patients. A 12 week programme was offered, six one to one sessions and six telephone calls.

Staff also offered stop smoking one to one sessions which they found popular with patients. There had been some success, but also setbacks. They were consulting with the pharmacy advisor to source additional nicotine alternatives. They recognised the challenge who needed to lose weight but were hampered from exercise through their long term condition. They also recognised the challenge to some patients by the closure of local services, such as the day centre, which had impacted on some patients' health and well-being.

They had signposted patients to carers' checks, to smoking advice, and to health checks for people aged 40 – 75, including consent for sharing information.

All newly registered patients were offered a consultation. A template was used to make sure of a comprehensive assessment. Nursing staff asked about their family history, alcohol and smoking consumption, height and weight, occupation, and any allergies. The GP then reviewed their medication.

Good

Are services effective?

(for example, treatment is effective)

The practice were looking at health promotion in collaboration with other practices, for example approaching schools directly. Part of their area had a high rate for teenage pregnancy.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from patients was positive about the way staff treated people. All the patients who spoke with us felt GPs, nurses and other staff were friendly, approachable and professional and they felt supported and well cared for. We observed patients being treated with dignity, respect and kindness during all interactions with staff. Patients making enquiries at the desk were dealt with respectfully, efficiently and professionally.

Respondents said the nurses and GPs were very caring and they had received an excellent service. One patient said they had received first class treatment at all times including when they were really unwell and needed advice and an emergency appointment. Patients said their GP always listened to what they had to say. They were more than helpful and did everything they could to help. One person said they could never have coped without their GP's help and support.

Patients said their GP had given very good in-depth explanations when they needed further treatment. Others said the GP got the right information for them, listened to them and their questions had been answered. One said they were extremely lucky to have been fortunate enough to have a GP who made them feel at ease so they were not at all embarrassed to talk about their medical problems.

The NHS England's 2014 GP patient survey showed that more than the national average of respondents described their overall experience of their GP practice as good or very good, and the last time they saw their GP they were good or very good at treating them with care and concern.

In the waiting room, those patients sitting next to the reception desk could overhear some personal conversations but it is well signed that people need to be aware of confidentiality. The local area is a close knit community and staff knew some patients personally but were fully aware of the confidentiality protocols of the practice. There was not a notice offering a private room for a patient wishing to discuss confidential information but reception staff told us they could provide one of several rooms if necessary. The adjoining side room to each surgery could be used for patients to wait and reception staff would try their best to seek an alternative GP if any delays were envisaged. These were also used for people who may have special needs and find it difficult to wait in a busy waiting room.

A GP took responsibility as the Caldicott Guardian to ensure confidentiality within the practice, with patient information safeguarded and shared only as necessary. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing.

Care planning and involvement in decisions about care and treatment

Patients were involved and encouraged to be partners in their care and in making decisions, with any support they needed. Staff spent time talking to patients, and those close to them. They were communicated with and given information in a way that they could understand. Patients understood their care, treatment and condition. Patients told us they had confidence that the GP had made appropriate decisions about their care and they knew what the next steps should be if they needed treatment. One parent of a young child was very complimentary about the service and their consultations with a particular GP.

Patient/carer support to cope emotionally with care and treatment

Three patients told us of occasions when a GP had to be called for a home visit and the response was deemed very good. One patient who told us they had a terminal illness, stated that the GP called frequently on his way home from the surgery and it had become almost social as well as medical.

Patients felt they had enough time in their appointments to discuss their health concerns. Reception staff were aware of many patients who need a double appointment and would suggest it dependent on what condition was identified when making a call for an appointment. Patients said they felt comfortable talking to staff at the practice.

Notices were displayed in the waiting room of advocacy services that could be used to support patients.

There was a procedure in place to identify carers. There was a carers list and they were highlighted on the computer records and offered health assessments and advice on support available.

Good

Are services caring?

Socially isolated patients had been referred to a local visiting/befriending service, a memory café, and a private day care service.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. The GPs had individual lists, to promote continuity, and attached staff paid tribute to the focus on continuity of care within this practice. The practice enjoyed good working relationships with other teams, including midwives, health visitors, the community mental health team and palliative care nurses which led to well co-ordinated care provision. Community staff who spoke with us praised the practice for its outstanding communication and the accessibility of the health care professionals.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, which provided continuity of care. They confirmed they were seen or spoken with on the same day if they had an urgent need. All had an allocated GP but were happy to visit others in emergencies or if aware they were away from the practice, for example on holiday.

There was an effective appointment system in place to cover current demands. The manager maintained an appointment matrix which showed a high level of appointment availability. The practice kept the appointments system under constant scrutiny and adjusted it in response to patient need. Booking in advance had been extended from three to four weeks ahead. Antenatal appointments could be made up to eight weeks ahead. They had moved from 30% to 50% pre-booked which helped with service planning. They had held a survey about demand for appointments every two years, to demonstrate whether they were meeting assessed need.

There was an effective duty system, enabling all patients who needed a same day appointment to see a health care professional. A telephone triage service was in place. The duty team was made up of two GPs who had only eight booked appointments so they could respond to telephone calls. Sometimes a third GP was available to meet urgent needs, for example on the day following a bank holiday when the surgery could expect to be busy with health care needs accumulated over the long weekend. If a patient needed medical advice on the day they got it. The GPs thought they had the balance right between booked and 'on-the-day' appointments and they continued to monitor.

The nurse practitioner ran a clinic for minor illness for patients of all ages to be booked on the day to enable patients to be seen on the same day. This was provided all day on Mondays and Fridays, and on Wednesday mornings. She found that anxious parents often brought their babies on Fridays, to get advice before the weekend.

The practice recognised the challenge of communicating with teenagers. They had introduced a teen noticeboard, making changes to their web site and using twitter. They had been collaborating with other practices with the aim of reducing teenage pregnancies. They accommodated young patients who may have poor time keeping, with open type surgeries allowing them to be seen by a GP if they presented at reception, without much waiting or bureaucracy. They always booked in young patients when they asked, recognising their courage in coming to the practice. Patients came to the practice at 3.30pm after college, even if they were not registered there.

Single parents and frail elderly patients had been offered home visits in recognition of their difficulty in getting to the practice. Up to 12 home visits per day were made. GPs phoned the patient first to confirm the need for the visit.

Patients who spoke with us had found they had enough time during their appointments to discuss their health concerns. We found the number of appointments provided was very good. Nurses told us that the timing of appointments was being increased. Patients coming for COPD reviews had been offered 15 minute appointments, and this was increased to 20 minutes. Diabetic reviews were 20 minutes, but this was under review as more time was sometimes needed.

Following a patient survey changes are planned for the telephone system. A message handling system is to be introduced when the telephone system is upgraded. In the meantime the practice aims to answer all calls within four seconds.

Tackling inequity and promoting equality

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

The practice had recognised the needs of different groups in the planning of its services. For example, individual arrangements were made for homeless patients, for communication and providing regular medication.

The practice had access to online and telephone translation services and a practice manager who spoke both Cantonese and Mandarin whose translation skills were used regularly.

North Devon is a holiday destination, and the practice accepted temporary registration from holiday makers who arrived, bringing their dressings for regular wound care.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There were a variety of 'standard' chairs, some fabric padded, some without arms and some with arms which are helpful for patients with reduced mobility. Seating was arranged to ensure ease of wheelchair access. The check-in computer was lowered to enable wheelchair users to reach it more easily. The consulting rooms were well laid out and easy to access by disabled patients. A new treatment chair had been provided, with arms that lifted so the patient could swivel round to stand. This meant that transfers from a wheelchair were easy.

Where patients had a known hearing impairment the GP would be alerted via computer record, and would come to the waiting room to greet the patient rather than relying on the screen to summon them. There was no hearing aid induction loop installed at the practice, which could help patients who used hearing aids.

Access to the service

Patients said they could easily contact the practice to speak about their health concerns. Some said that getting allocated a named GP could take a couple of days, especially those only working part time. Opting for an alternative GP was likely to get an appointment the same day either personally or via telephone consultation if appropriate.

Patients said they did not have to wait long in the surgery, the maximum time was 5 – 10 minutes. One said that if the doctor was delayed, reception staff would inform them.

Patients confirmed they knew what to do to speak to a doctor out of hours. Practice opening hours were, 8:30am to 6pm, Monday to Friday, closed 1pm – 2pm. Extended hours were alternate Mondays and Tuesdays 7am – 8am and 6:30 – 7:30pm, Wednesdays and Thursdays 7am – 8am. The nurse practitioner ran a clinic for minor illness for patients of all ages to be booked on the day to enable patients to be seen on the same day. This was provided all day on Mondays and Fridays, and on Wednesday mornings. She found that anxious parents often brought their babies on Fridays, to get advice before the weekend.

Listening and learning from concerns and complaints

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

The complaints procedure was available on the practice web site and at reception. The policy clearly indicated the contact details for NHS England and the Health Ombudsman. Complaint forms were readily available in the reception area. There was also information on the digital display screens.

If a patient complained they were given a copy of the complaints procedure to ensure the patient is fully aware of the process. All complaints were discussed and actions agreed. Learning points were documented. Three complaints and 13 compliments had been recorded since April 2014. The complaints had been appropriately dealt with. The clinical staff were involved in resolving complaints if the complaint referred to a clinical issue or if the complaint was regarding a health care professional. All complaints that referred to the administrative side were dealt with by the management and administrative staff who were involved. Complaints were discussed at partners meetings every month and discussed in individual team meetings as appropriate.

Staff told us that any complaints were discussed during their regular lunchtime sessions. The patient questionnaire included the opportunity to make complaints and was emailed to all staff. Difficulties with parking were often mentioned. They had seen how this impacted on patients when they had their blood pressure measured. The practice had plans that would make additional provision.

Are services well-led?

Good

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

Our findings

Vision and strategy

There were clear vision and values, driven by quality and safety, which reflected compassion, dignity, respect and equality. There was a clear and realistic strategy. Staff knew and understood the vision, values and strategy. From a patient point of view the practice was working well and in keeping with their mission statement which was to deliver consistent quality of care to patients within available resources. GPs told us they consulted with all employed and attached staff including health visitors, midwives, community nurses and the patient participation group (PPG).

Strategic planning meetings were held monthly, with the partners and practice manager. The GPs responded to population growth in the area by planning to expand the group of partners and their capacity for providing health promotion. Negotiations over an additional building were on-going.

Governance arrangements

Robust governance procedures were in place. All staff were aware of the governance policies and procedures which were available on the practice intranet. Governance issues and training were discussed during team meetings.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The reception team, treatment room team, and partners, all had their own monthly meetings, which were minuted and provided leadership with openness and transparency.

The partners also attended an away day once every year to give them an opportunity to get together to discuss business and clinical issues.

Clinical meetings took place monthly to discuss process changes within the practice, for example, alterations to the incentive schemes. GPs told us their clinical governance was monitored with the support of a consultant surgeon from the local district general hospital, for external scrutiny.

Attached staff told us they were welcomed by the practice to their daily coffee meetings and the educational meetings.

Practice seeks and acts on feedback from its patients, the public and staff

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns.

Nurses met and 'buddy up' for clinical supervision. They attended the nurses' forum or the nurse practitioner group. They had brought back ideas which they had been enabled to introduce to the practice. For example, now disposable instead of metal cups were used for ear syringing.

Nurses told us that management had encouraged them to be involved in shortlisting and interviewing candidates during recruitment. They told us they were very pleased with the new team, resulting from the recruitment.

There was an active Patient Representative Group (PPG) which had been running for four years and met every four months. They assisted with promoting the centre.

We spoke with two PPG members. They told us a GP and a manager generally came to their meetings. The practice manager provided the agenda. Topics discussed had included facilities for patients and telephone access. They told us the practice was able to accommodate their request for longer appointments. Also, a new telephone system was being introduced, in response to patient requests, to direct patients to the correct department.

Some PPG members had assisted in childhood development clinics. There had been fund raising activities and the PPG had bought equipment for the practice, for example, a defibrillator, blood pressure cuffs and an ear syringe.

Some PPG members said they had found that recently the meetings had been used for disseminating information from the practice rather than listening to their views and

that a GP had not always attended. We saw from minutes that a GP had attended the meetings of March and July 2014. The group were keen to promote the practice, to improve facilities for patients and carers. The minutes of a recent meeting showed they were planning to set up a virtual PPG group, to enable more patients to contribute their views. This would be in addition to the actual group, with its main function being consultation.

The PPG reported back four main issues from their last survey;

1. Car parking, which had been a long term issue. PPG members might be asked to patrol a new scheme.
2. Telephone access;- patients were to be encouraged to plan ahead and avoid same day requests where possible.
3. Facilities in the waiting area. The toilet had been improved with new flooring, redecoration, restocking twice a day, and a wall mounted baby changing unit had been installed.
4. Privacy for patients at reception;- clearer signage was to be installed to advise patients of a confidential area being available – we did not see this in place. Advice about where to stand when queuing was displayed, and staff had been trained to ask patients to confirm their details, rather than the staff reading out this information.

Management lead through learning and improvement

GPs told us the team were proud to share their successes and they also supported each other by sharing in any failures. A 'staff praise board' displayed comments and letters from patients, other staff members which was a good morale booster. The board was cleared every month, so all compliments and thanks were current.

The departmental leaders were responsible for monitoring their teams training. A training matrix was displayed on the practice intranet that showed training achieved and training required by team members.

The practice closed four afternoons per year in response to a CCG incentive. This was allocated training time for all staff. The time was used for group training sessions and an outside trainer attended. Sometimes the training sessions were opened up to other practices to attend, which was good for networking as well as promoting integrated working.

There was a strong focus on continuous learning and improvement at all levels of the organisation. The NMC charges for continued registration were refunded to the nurses as good practice. Nurses told us they were pleased with their support and proud of the quality of the practice.

The practice was a training practice. GPs were responsible for mentoring the GP registrars and medical students. A medical student praised the support they had been given. They thought it was a great teaching surgery, with the range of experience and level of support needed. They had done home visits with nurses and HCAs, visited undertakers, and had sufficient study time. A registrar told us they were well supported with good training. Two GPs were trainers, which was a benefit. They attended practice lunchtime clinical meetings twice weekly. There was a broad spectrum of ages and experience amongst the GPs, who were all prepared to make time for team members.

Staff told us of the appraisal system. The practice manager sent a form for the staff to consider and complete before their meeting, then the GP and line manager made comments on the person's performance and training needs. Staff told us the practice manager and senior nurses had been brilliant with supporting their training. Specific training was provided in accordance with individual needs and interests. For example, a nurse had been on training for carpal tunnel with the GP she had been working with for several years. Another nurse told us this was the best job ever, because of the patients and the team.

There was an occupational service available for staff to use. GPs told us they had stress management meetings on a regular basis, with a facilitator.