Budleigh Salterton Medical Practice

Quality Report

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Date of inspection visit: 28 April 2016
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Budleigh Salterton Medical Centre on 28 April 2016. Overall the practice is rated as outstanding.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Feedback from patients about their care was consistently and strongly positive.
- The practice website could be translated into other languages to assist in removing language barriers. The foyer touch screen sign in system had the languages known to the practice of the patient groups and could be updated if a further language was requested. All staff knew how to book an interpreter when required. Makaton cards for learning disability patients were available for use in all consulting rooms. A hearing loop was available at the reception desk.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Telephone consultations were available for patients and patients could book appointments online via computer or phone app. Patients could email the practice directly for advice.
- The practice had an informative website and a range of patient leaflets in the practice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.
- The practice was involved in piloting studies for clinical research, to seek improvements for patient outcomes.

Summary of findings

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.

We saw several areas of outstanding practice:

- The practice was actively seeking to engage with children to hear their views about facilities and staff friendliness. The practice had adapted a version of the Friends and Family Test for children. This was a simpler form that included facial expressions to indicate levels of satisfaction. We saw children were completing these feedback forms and this had led to improved child friendly facilities in the waiting area.
- The practice had identified that the prevalence of dementia amongst patients registered at the practice was approximately double that of the local CCG and national averages. The practice funded and staffed a community based memory café in Budleigh Salterton, which met twice a month. The café provided practical information and support, as well as the opportunity for people with dementia, their families and carers to ask questions and to listen to others experiences. Nurses and health care assistants from the practice facilitated the sessions and spent one to one time with patients and their carers' at the café, talking about individual needs and taking action to refer patients and carers back to the practice for action, referral or signposting.
- The practice employed a health care assistant with a specific role of managing vulnerable older patients in the community, alongside the patients' named GP. They had continued this service at their own expense after the original funding had ceased. The practice had identified over 500 patients over 80 who lived alone. The aim was to keep patients safe in their own homes and to ensure their long term needs and wishes were met with dignity and respect. All identified patients were contacted and support was offered in a variety of ways, from referrals to GPs for home visits or social services support assessments, to ensuring patients had sufficient supplies of food at home.
- A nominated member of staff had dedicated clinics for supporting carers. The first appointment was for an hour with a follow up appointment every six months or sooner if required. The assessment in the clinic was tailored to provide help with carers' emotional and social needs as well as their physical needs.
- The practice used resources effectively to make a difference to the patient population. The practice was rurally located and all GPs had a defibrillator in their personal cars. They were therefore able to respond to emergencies in the community. An example was given of when this was effectively used for a member of the public at a sports event where a GP was spectating.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

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

Are services caring?

Good

The practice is rated as good for providing caring services.

- Feedback from patients about their care and treatment was consistently and strongly positive.
- We observed a strong patient-centred culture.
- Views of external stakeholders were positive and aligned with our findings.
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- There were innovative approaches to providing integrated person-centred care. For example, the practice funded and staffed a community based memory café in Budleigh Salterton, which met twice a month.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- The practice staff were particularly aware of the vulnerability of older patients who lived alone. For example, an audit was done on all patients over 80 to establish who had not been seen in the last 12 months. Patients who'd had no contact with the practice were referred to their GP to make contact and all were followed up, either in the practice or as a home visit.
- Patients could access appointments and services in a way and at a time that suited them.
- Telephone consultations were available for patients who were at work.
- The practice offered online access via computer or phone app.
- Patients could email the practice directly for advice.

Are services well-led?

Outstanding 

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

Summary of findings

- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable.
- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- There was effective and constructive engagement with staff and a high level of staff satisfaction.
- The practice had a very active patient participation group (PPG) which influenced practice development.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

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

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older patients, and offered urgent appointments for those with enhanced needs.
- A dedicated GP was allocated to local nursing homes with patients registered at the practice for continuity of care.
- Feedback from three local care homes for older people, representing approximately 90 patients registered with the practice, was positive, citing a responsive GP practice and good professional relationships.
- The practice employed a health care assistant with a specific role of managing vulnerable older patients in the community, alongside the patients' named GP.
- Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.
- The practice provided office accommodation for the Hospiscare service in Devon and district nursing team. This aided communication between them and the practice staff to engender a coordinated approach to patient care.
- The practice offered facilities (phone and consulting room use) to the 'Neighbourhood Friends Scheme' run by a local charity with a volunteer led befriending service for older or vulnerable people. Patients from the practices list benefitted directly from this service.

People with long term conditions

Outstanding ☆

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The monitoring and treatment of patients identified as having diabetes and at risk of complications from the condition was comparable with local CCG and national averages.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Longer appointments and home visits were available when needed.
- The practice offered a nurse led leg ulcer service.
- A nominated member of staff had dedicated clinics for supporting carers. The first appointment was for an hour with a follow up appointment every six months or sooner if required. The assessment in the clinic was tailored to provide help with carers' emotional and social needs as well as their physical needs. These interventions helped the patients to remain in the community for longer and for their carer to continue caring for longer.
- Practice staff were leading research into four current clinical trials for patients with long-term conditions. This included research into depression and anxiety therapies, chronic kidney disease, irregular heartbeats and further complications risk and prevention of gastrointestinal bleeds.

Families, children and young people

Outstanding ☆

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The percentage of patients diagnosed with asthma, on the register, who had an asthma review in the last 12 months was 80%. This was comparable with both local CCG and national averages of 76%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The percentage of women eligible for cervical screening who had received a smear test within the recall programme was 78%. This was in line with the CCG average of 77% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice waiting room had a children's area with a train table, books and child friendly seats. There was an information board providing child health information for parents in the children area.
- The practice had adapted a version of the Friends and Family Test for children. This was a simpler form that included facial expressions to indicate levels of satisfaction.
- One of the GPs was leading the practice in the UNICEF baby friendly initiative. This, amongst other goals, promoted breast feeding for infants and supported new mothers to do so.
- Practice staff told us that all young infants and young children were fitted into clinics without an appointment if a parent/ guardian was concerned about the childs' health.
- The practice had a 'teenager's confidentiality policy'. This educated reception staff and promised teenage patients that their reason for visiting the practice would remain confidential up to the point of seeing the clinician. The aim of the policy was to promote trust in GPs for young patients.
- The practice provided a GP service for a local term time further education college.
- On the practice website were a pregnancy care planner, childhood immunisations information, teen and young adult practice information and health education WEB links.
- People holidaying in Budleigh Salterton could register at the practice as a temporary patient and be seen on the same day if the need was urgent.

Working age people (including those recently retired and students)

Outstanding ☆

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- There were varied extended hours with a GP. Morning clinics were available from 7am until 8am, evening clinics 6.30pm until 7.30pm and monthly Saturday morning clinics from 8.30am until 10.30am. These were available for booking over the phone or online up to six weeks in advance.
- Telephone consultations were available for patients who were at work.
- The practice offered online access via computer or phone app.

Summary of findings

- Patients could email the practice directly for advice.
- There were daily 'extras' clinics starting at 5pm until all patients requesting an appointment had been seen. These extras appointments were offered to everyone who was unable to attend during normal clinic hours and needed to be seen on the same day by a GP.
- Well man / woman checks were available on request.
- The practice had an informative website and a range of patient leaflets in the practice.

People whose circumstances may make them vulnerable

Outstanding ☆

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

- The practice held a register of patients living in vulnerable circumstances including homeless patients and those with a learning disability.
- The practice actively helped the occasional homeless person and their additional needs through the provision of an emergency sleeping bag and by directing these people to a nearby homeless service.
- The practice offered longer appointments for patients with a learning disability.
- 100% of patients with a learning disability had received an annual health check.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations, such as drug and alcohol support services.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice website could be translated into other languages to assist language barriers. The foyer touch screen had the languages known to the practice of the patient groups and could be updated if a further language was requested.
- Makaton cards for learning disability patients were available for use in all consulting rooms.
- A hearing loop was available at the reception desk.
- The practice made food bank referrals via email for vulnerable patients and employed a health care assistant to reach out to these patients who had not engaged in services, such as for routine health reviews.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

- 80% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had an agreed care plan that had been reviewed in the last 12 months was 98%. This compared favourably to the CCG average of 87% and the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice funded and staffed a community based memory café in Budleigh Salterton, which met twice a month.
- Practice staff had been trained in dementia awareness.
- The practice manager represented the practice on the East Devon Coastal Dementia Alliance, a forum for adding dementia resources, such as providing dementia training for local shopkeepers, in the local area.
- The practice was working towards 'iSPACE', which is a dementia friendly primary care project with the purpose of improving upon patient and carer experiences, teamwork and clinical consultations.
- Local depression and anxiety service information was available in the practice and on the website. The website included a link for self-referral if patients did not want to attend the practice.
- The practice was piloting Morita Therapy, a talking therapy as an alternative approach to managing depression and anxiety.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing better than local and national averages. 239 survey forms were distributed and 145 were returned. This represented approximately 1.8% of the practice's patient list.

- 94% of patients found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group average of 85% and a national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 85% and national average 76%).
- 96% of patients described the overall experience of their GP surgery as good (CCG average 91% and national average 85%).
- 93% of patients said they would recommend their GP surgery to someone who has just moved to the local area (CCG average 87% and national average 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards which were all positive about the standard of care received. Patients told us it was easy to obtain appointment, that staff were kind and professional in their interactions with them.

We spoke with 11 patients during the inspection and received one comment through the CQC 'share your experience' web address. All patients said they were happy with the care they received and thought staff were approachable, committed and caring.

Feedback from three local care homes for older people, representing approximately 90 patients registered with the practice, was positive, citing a responsive GP practice and good professional relationships.

We looked at comments patients had made about the practice on the NHS Choices website. The feedback was overwhelmingly positive. Were there was a negative comment, the practice had engaged with the person who posted the comment to resolve their grievance.

The practice engaged in the Friends and Family Test survey. During 2015 a total of 398 patients completed survey responses. 95% of patients advised they would be extremely likely / likely to recommend the practice to family and friends. The practice displayed the Friends and Family survey results and any responses to patient comments about how to improve the practice via the practice website and on notice boards in the practice patient waiting areas.

Outstanding practice

We saw several areas of outstanding practice:

- The practice was actively seeking to engage with children to hear their views about facilities and staff friendliness. The practice had adapted a version of the Friends and Family Test for children. This was a simpler form that included facial expressions to indicate levels of satisfaction. We saw children were completing these feedback forms and this had led to improved child friendly facilities in the waiting area.
- The practice had identified that the prevalence of dementia amongst patients registered at the practice was approximately double that of the local CCG and national averages. The practice funded and staffed a community based memory café in Budleigh Salterton, which met twice a month. The café provided practical information and support, as well as the opportunity for people with dementia, their families and carers to ask questions and to listen to others experiences. Nurses and health care assistants from the practice facilitated the sessions

and spent one to one time with patients and their carers' at the café, talking about individual needs and taking action to refer patients and carers back to the practice for action, referral or signposting.

- The practice employed a health care assistant with a specific role of managing vulnerable older patients in the community, alongside the patients' named GP. They had continued this service at their own expense after the original funding had ceased. The practice had identified over 500 patients over 80 who lived alone. The aim was to keep patients safe in their own homes and to ensure their long term needs and wishes were met with dignity and respect. All identified patients were contacted and support was offered in a variety of ways, from referrals to GPs for home visits or social services support assessments, to ensuring patients had sufficient supplies of food at home.
- A nominated member of staff had dedicated clinics for supporting carers. The first appointment was for an hour with a follow up appointment every six months or sooner if required. The assessment in the clinic was tailored to provide help with carers' emotional and social needs as well as their physical needs.
- The practice used resources effectively to make a difference to the patient population. The practice was rurally located and all GPs had a defibrillator in their personal cars. They were therefore able to respond to emergencies in the community. An example was given of when this was effectively used for a member of the public at a sports event where a GP was spectating.

Budleigh Salterton Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Budleigh Salterton Medical Practice

Budleigh Salterton Medical Centre is situated in Budleigh Salterton, a small Devon coastal town situated in an area of outstanding natural beauty. The practice serves approximately 8,000 patients from Budleigh Salterton, the surrounding villages and provides a GP service to Bicton further education college.

The patient list is diverse in terms of social deprivation. One ward of the practice has the lowest life expectancy in Devon, whilst in another ward of the practice there is the highest life expectancy in Devon. The practice has higher than national and local CCG averages of the number of older people in its patient demographic profile.

The practice is a two storey building, with allocated parking spaces for disabled patients to the front of the building and an automatic push button entrance doors with no steps. On the ground floor there are eight consulting rooms, a minor operations room, a nurse's room and two toilets (one is accessible for patients with mobility difficulties or disabilities). On the first floor there are the administration rooms and staff areas.

The practice has six GP partners and one salaried GP. Three are female and four are male. Three of the GPs are full time and four are part time. There is a practice manager, who is supported by two assistant managers. There are two practice nurses offering general nursing clinics and clinics for baby immunisation, travel, well person, smoking cessation, cervical smear, leg ulcers and long term condition management clinics in asthma and diabetes. There are three health care assistants and one phlebotomist (a person who takes blood). Ten administrative and reception staff complete the staff team at the practice.

Budleigh Salterton is a training practice for GP registrars, a teaching practice for medical students in years two to five of their course at medical school and a teaching practice for student nurses enrolled at Plymouth University.

The practice opened and appointments were available between 8am until 6.30pm Monday to Friday. Bookable extended hours appointments for patients who find it difficult to attend normal surgery times due to work commitments, school or personal choice. were available at the following times: Monday 7am until 8am, Tuesday 7.30am until 8am, Monday 6.30pm until 7.30pm. There were also extended hours appointments one Saturday per month between 8.30am and 10.30am.

Outside of opening hours patients are directed to the Devon Doctors out of hours service. This is accessed via the 111 telephone service.

Regulated activities for Budleigh Salterton Medical Centre are carried out from one location.

Budleigh Salterton Medical Centre.

1 The Lawn,

Detailed findings

Budleigh Salterton,

Devon,

EX9 6LS.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 April 2016. During our visit we:

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

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a clinical sample had been mislabelled. This was recorded as a significant event, discussed with the whole staff team and a system was agreed for attaching all spare labels to the patient's record. This type of incident had not reoccurred.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. Following feedback to the practice during the inspection visit the practice amended the chaperoning posters to inform patients that GP and nurses may, on occasion, also request the presence of a chaperone during a patient examination.
- All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken (each June) and we saw evidence that action was taken to address any improvements identified as a result. For example, as a result of the June 2015 audit two consulting rooms had been upgraded with improved facilities. Non-permeable sheets had also been provided in consulting rooms that remained carpeted, for use when performing dressings. The annual practice business plan listed further upgrade which included new vinyl flooring for two nurses' consultation rooms.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (Patient Group Directions (PGDs) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccinations after specific training when a GP or nurses were on the premises.

Good

Are services safe?

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives.
- The practice had a fire risk assessment and carried out quarterly fire drills. There was a quarterly test of the fire alarm. We raised the suitability of a quarterly test of the fire alarm with the practice manager. The fire risk assessment was simple and had not identified the need to highlight the storage of oxygen on the premises. We raised this with the practice manager. They wrote to us following the inspection to confirm that oxygen notices had been sourced and were now placed in areas where oxygen was stored. The practice also sent us a revised premises fire risk assessment. This was now a comprehensive risk assessment and now stated that the fire alarm would be tested on a weekly basis.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Water systems were tested on a monthly basis to prevent the spread of the legionella bacterium.
- The practice retained a wheelchair for patient use. There was not a system in place for regular maintenance of the wheelchair or any notice regarding liability if patients used the wheelchair without staff assistance. We raised this with the practice. The practice took action to address this and wrote to us to tell us that a protocol for use of the wheelchair had been developed and placed by the wheelchair and that a monthly maintenance check and risk assessment had been implemented.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There were systems in place to seek staff cover for any absences. For example, most of the non-clinical staff were part time, but had completed training to cover staff absences, such as phlebotomy (blood taking). Part time staff were able to cover staff sickness at short notice by working additional hours. The practice told us that visitor numbers in the summer months swelled the patient list by up to an additional 5000 temporary holidaymakers. Staff said patients could register and be seen on the same day, if the need was urgent. The practice manager said staffing provision was planned for during these times of additional patient demand.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services safe?

- All GPs had a defibrillator in their personal cars enabling them to respond to emergencies in the wider, often rural, community. An example was given of when this was effectively used for a member of the public at a sports event where a GP was spectating.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- All GP referrals to secondary care were GP peer reviewed on a daily basis.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available. The practice had a dedicated staff member to search for any QOF indicator exclusions on a bi-annual basis. Those patients not meeting the inclusion criteria or previously excluded were flagged up to the patients' GP for further investigation/discussion. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- 80% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had an agreed care plan that had been reviewed in the last 12 months was 98%. This compared favourably to the CCG average of 87% and the national average of 88%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the CCG and national average at 84%.(The CCG average was 85% and the national average was 84%).

Clinical audits demonstrated quality improvement.

- We looked at ten clinical audits completed in the last two years. Two of these were completed audits where the improvements made were implemented and monitored. Most audits appeared to be reactive rather than as a result of agreeing an annual plan of audit at the practice. Following the inspection the practice manager wrote to us and told us that since the inspection the partners have decided that at the start of each month a clinical audit will be decided at the practice meeting with a view to auditing and discussing results at the end of the month. In addition each GP would undertake an audit pertinent to their own speciality annually and share the results with their peers.
- Findings were used by the practice to improve services. For example, an audit had been done on all patients over 80 to establish who had not been seen in the last 12 months. The audit identified 992 patients, of which 20 had no contact with the practice in the last 12 months. All of these patients were referred to their GP to make contact and all were seen either in the practice or as a home visit.
- Practice staff used audit to identify further training needs. For example, action taken included a GP registering to complete an advanced course in dermoscopy following a self-audit of their two week wait skin referrals.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those staff reviewing patients with long-term conditions.
- Staff administering vaccinations and taking samples for the cervical screening programme had received specific

training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months.
- Medical and nursing students were provided with their own IT equipped room for use to reflect upon learning experiences whilst on placement at the practice.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example, when referring patients to other services. This included providing a summary of patients identified at most risk of admission to hospital for the out of hours Devon Doctors service available through a shared IT system. When patients were referred to accident and emergency services the practiced telephoned the emergency hospital department, faxed them a summary of the emergency and provided a letter to accompany the patient presenting at the hospital.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits
- Feedback from three local care homes, with patients registered at the practice, was that the GPs at the practice actively engaged in issues of assessing mental capacity and patient wishes regarding on-going investigations and treatment. The care homes said expert advice, such as from Independent Mental Capacity Act advocates or community based psychiatric nurses, was sought by the GPs where appropriate and relevant.

Supporting patients to live healthier lives

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

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, alcohol intake and smoking cessation. Patients were then signposted to the relevant service.
- Smoking cessation advice was available from specifically trained practice staff.
- One of the GPs was leading the practice in the UNICEF baby friendly initiative. This, amongst other goals, promoted breast feeding for infants and supported new mothers to do so.

Good

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 78%. This was in line with the CCG average of 77% and slightly below the national average of 82%.There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 83% to 100% and five year olds from 92% to 99%. The CCG average ranges for under two year olds was 82% to 98% and for five year olds between 91% to 97%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Phone calls to the practice were diverted to an administrative area away from the main reception desk. This meant that telephone conversations could not be overheard and reception staff were solely focussed on attending to patients in the practice.
- The practice was community minded and staff responded to emergencies that happened on the streets surrounding the practice, for example, in response to trips and falls.
- The practice offered facilities (phone and consulting room use) to the 'Neighbourhood Friends Scheme' run by a local charity with a volunteer led befriending service for older or vulnerable people. Patients from the practices list benefitted directly from this service. Trained volunteers signposted patients to appropriate services and carried out supportive services such as collecting a pint of milk for somebody recently discharged from hospital; helping someone get to a GP appointment; collecting a prescription; feeding a pet while someone was in hospital; enabling someone to access a falls assessment or rehabilitation exercise class; cooking a meal for someone returning from hospital; telephoning an isolated person for a 20 minute chat once a week.
- The practice made food bank referrals for vulnerable patients and employed a health care assistant to engage with patients who had not engaged in services, such as for routine health reviews.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 91% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 92% and national average of 87%.
- 90% of patients said the GP gave them enough time (CCG average 90% and national average 87%).
- 100% of patients said they had confidence and trust in the last GP they saw (CCG average 97% and national average 95%).
- 90% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 90% and national average 85%).
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG average 93% and national average 91%).
- 93% of patients said they found the receptionists at the practice helpful (CCG average 90% and national average 87%).

The practice worked with and referred patients to the Budleigh Salterton Health Centre charity. The charity was inaugurated in 1996. The objective of the charity was 'to relieve sickness and preserve health amongst persons permanently or temporarily resident in the catchment area of Budleigh Salterton Medical Centre or any legal successors thereof'.The charity provided equipment and facilities for the direct benefit of patients over and above that which was normally found inroutine medical practice. For example, to support modernisation of the practice facilities, the charity provided facilities within the minor

surgical unit and the décor within the practice. The charity recently provided defibrillators for every GP to enhance emergency medical treatment across the wider community.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. We heard examples of compassionate care, for example, tailoring checks with learning disability patients to suit their capacity to manage this. Such as breaking the checks into smaller consultations over a period of time if the patient was not able to concentrate for the duration of a single consultation slot.

Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 90% and national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 87% and national average 82%)
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 88% and national average 85%)

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The register of carers was audited quarterly. The practice had identified 195 (1.7%) of the practice list as carers. There was an alert on the patient's records to advise the GP if they were a carer. To improve on the current system a staff member was in the process of updating records on emergency contacts to advise the GP if the patient being cared for was able to be left for any periods of time, or whether intervention was needed if there was a crisis.

A nominated member of staff had dedicated clinics for supporting carers. The first appointment was for an hour with a follow up appointment every six months or sooner if required. The assessment in the clinic was tailored to provide help with carers' emotional and social needs as well as their physical needs. The practice had links with Devon Carers and information for patients was available in the practice and on the practice website.

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patient's individual needs and preferences were central to the planning and delivery of flexible services that provided choice and ensured continuity of care.

- Telephone consultations were available for patients unable to attend the practice.
- The practice offered online access via computer or phone app.
- Patients could email the practice directly for advice.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had difficulty attending the practice.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccinations available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice was accessible with all clinic rooms with ground floor level access.
- The practice was the GP service for a local term time further education college. Approximately 220 students were residential, and for many, this was their first time away from home. Practice staff attended fresher's week and offered on campus health assessments for students wishing to register. The college was in a rural area with an infrequent bus service, so students would not find it easy to attend the practice. The practice ran a weekly GP clinic at the college and saw any student needing to be seen acutely on the day, when their lessons were finished. The practice nurse led sexual health talks, giving advice on contraception and advice, such as on smoking cessation. We received feedback from the college, who described this as an irreplaceable educational and health resource for the students.
- Feedback from three local care homes for older people, representing approximately 90 patients registered with the practice, was positive, citing a responsive GP practice and good professional relationships.
- The practice website could be translated into other languages to assist language barriers. The foyer touch screen had the languages known to the practice of the patient groups and could be updated if a further language was requested. All staff knew how to book an interpreter when required.
- Makaton cards for learning disability patients were available for use in all consulting rooms.
- The practice produced a seasonal patient newsletter in conjunction with the patient participation group, detailing services offered, community health and social events and patient feedback responses and actions to act on such feedback.
- The practice employed a health care assistant with a specific role of managing vulnerable older patients in the community, alongside the patients' named GP. They had continued this service at their own expense after the original funding had ceased. The practice had identified over 500 patients over 80 who lived alone. The aim was to keep patients safe in their own homes and to ensure their long term needs and wishes were met with dignity and respect. All identified patients were contacted and support was offered in a variety of ways, from referrals to GPs for home visits or social services support assessments, to ensuring patients had sufficient supplies of food at home.

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patients' needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for patients with multiple and complex needs.

- The practice had identified that the prevalence of dementia amongst patients registered at the practice was approximately double that of the local CCG and national averages. The practice funded and staffed a community based memory café in Budleigh Salterton, which met twice a month. The cafe provided practical information and support, as well as the opportunity for people with dementia, their families and carers to ask questions and to listen to others experiences. It also offered an informal and social environment in which to

learn new skills, undertake meaningful activities and listen to guest speakers. This initiative provided practice staff with a holistic assessment of patients suffering with memory impairment, including their physical, social and emotional needs and those of their carer. This was achieved by nurses and health care assistants employed at the practice spending one to one time in the two hour café sessions talking about individual needs and taking action to refer patients and carers back to the practice for action, referral or signposting.

- The partners at the practice were leading a community project within Budleigh Salterton with the aim to create a well-being hub based around the community hospital. The intention was to bring together social care and the voluntary sector including an intergenerational aspect appealing to all members of the community. The aim was that the well-being hub, facilitated by the practice, would be underpinned by re-ablement services and specialist medical and allied medical clinics as a focal point for clinical care. The pilot project aimed to test the feasibility of the model and how this might be implemented in other parts of Eastern Devon and wider CCG area in the future.

Access to the service

The practice was open between and appointments were available between 8am and 6.30pm Monday to Friday. Bookable extended hours appointments for patients who found it difficult to attend normal surgery times due to work commitments, school, etc. were available on Monday 7am until 8am, Tuesday 7.30am until 8am, Monday 6.30pm until 7.30pm. There were also extended hours appointments one Saturday per month between 8.30am and 10.30am. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

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

- 87% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 82% and national average of 78%.
- 94% of patients said they could get through easily to the surgery by phone (CCG average 85% and national average 73%).
- 57% of patients said they usually get to see or speak to the GP they prefer (CCG average 48% and national average 36%).

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

- Patients needing to be seen that day were never turned away. The practice ran a daily 'extras' clinic where GPs kept their lists open until the last patient requesting an appointment was seen. Figures for January 2016 showed an additional 246 patients on this extras list were seen.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, such as in posters and leaflets for patients available in the waiting room and on the practice website.

We looked at six complaints received in the last 12 months and found these had been satisfactorily handled, dealt with in a timely way, with openness and transparency. Lessons were learnt from concerns and complaints and action was taken to improve the quality of care. For example, a change in policy was implemented to when receiving blood results to enable staff to add 'free text' to a result, where there was an issue for wider discussion. A further example was a review of policy and additional staff training in the process for preparing injections following a patient complaint. Learning from all complaints was shared in whole staff team meetings to promote an open staff culture to learning from complaints raised.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

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

- The practice had a mission statement which was displayed in the waiting areas and in the practice patient information booklet. Staff knew and understood the values. The mission statement was: 'We endeavour to provide the highest quality healthcare prioritising compassion and safety in all that we do. We value our position within our community and working with our partner organisations to promote wellbeing in the area we serve'. Our observations and the views of patients concluded the practice was achieving mission to provide this level of care.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management. Leaders had an inspiring shared purpose and there was strong collaboration and support across all staff with a common focus on improving quality of care and patients' experiences.

- Staff told us the practice held regular team meetings. For example, there were weekly clinical team meetings. Hospiscare (Devon) nurses and district nurses attended the clinical meeting once a month. There were weekly complex care team meetings and fortnightly meetings to discuss children and families at risk. We saw these meetings resulted in clear communication between the practice and the wider multi-disciplinary teams which patients benefitted from through clear action plans.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. We noted team development days were held twice yearly. Staff told us they felt the staff team had a strong professional bond and communicated well at the practice.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice was a teaching and training practice for GPs, medical students and student nurses. Practice staff had received specific training in mentoring trainees.

Seeking and acting on feedback from patients, the public and staff

Are services well-led?

Outstanding ☆

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

The practice encouraged and valued feedback from patients, the public and staff. The practice sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met between every six weeks and two months. The PPG carried out patient surveys and submitted proposals for improvements to the practice management team. The PPG produced a newsletter, which was available in the practice. The PPG was also forward thinking, for example, it had arranged and hosted public health talks in the local community on topics such as asthma, diabetes, prescribing and blood pressure. The next scheduled talk was entitled 'What the future hold for general practice.' The PPG were trying ways to better engage with younger people to be active within the group. This included approaching local secondary schools to design a new logo for the group and speaking with schools about what a PPG does. The PPG said they had actively been engaged in driving improvements to the practice appointment system. To do this they commissioned a patient survey specifically to look in depth at improvement that could be made. The PPG members told us that the practice were responsive to patient needs, supportive and worked with them to engage with the community to promote good health, such as through the series of public health talks.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, minutes of the staff development day on 16 March 2016 showed a discussion rose within the staff team regarding confidentiality of patient records. It was agreed as an action from the meeting that staff would compile a list of any family members also registered at the practice and electronically these notes would be restricted to ensure staff working at the practice did not have access to family members' medical records. Staff told us they felt involved and engaged to improve how the practice was run.
- The practice was actively seeking to engage with children to hear their views about facilities and staff friendliness. The practice had adapted a version of the Friends and Family Test for children. This was a simpler form that included facial expressions to indicate levels of satisfaction. We saw children were completing these feedback forms and this had led to improved child friendly facilities in the waiting area.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and were driving local pilot schemes to improve outcomes for patients in the area that sought to embed new ways of providing care and treatment.

- Practice staff had protected time for research projects. For example, one of the practice nurses was piloting Morita Therapy, a talking therapy as an alternative to managing depression and anxiety.
- A second nurse led research study involved a breath test for Helicobacter pylori (bacteria that grow in the digestive tract and have a tendency to attack the stomach lining) in patients on long term Aspirin and who might be at risk of gastrointestinal bleeds.
- A third study was investigating patients with newly diagnosed atrial fibrillation (irregular heart beat) and one other risk factor, to determine the treatment of their diagnosis and assess the risk of stroke and systemic embolisation (a blockage in a blood vessel).
- The practice was in the process of setting up a three year study into the use of spironolactone (a medicine that prevents the body from absorbing too much salt and keeps potassium levels from getting too low), for cardiac protection in chronic kidney disease patients.
- The partners at the practice were leading on a community project within Budleigh Salterton with the aim to create a well-being hub based around the community hospital. The aim was to bring together social care and the voluntary sector including an intergenerational aspect appealing to all members of the community. The pilot project aimed to test the feasibility of the model and how this might be implemented in other parts of Eastern Devon and the wider CCG area in the future. In 2014 one of the partners was shortlisted for the Health Service Journal

Are services well-led?

Outstanding ☆

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

(sponsored by the British Medical Association) clinical leader of the year award following his work in developing the health and social care hub at the community hospital in Budleigh Salterton.

- The practice was a teaching and training practice for GPs, medical students and student nurses. Practice staff had received specific and ongoing training in mentoring trainees.