Drs Twomey, Murphy, Braddick, Griffiths, Fearon and Kirwan

Quality Report

Chiddenbrook Surgery
Threshers
Crediton
Devon
EX17 3JJ
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as good overall. (The previous inspection of Drs Twomey, Murphy, Braddick, Griffiths, Fearon and Kirwan (known as Chiddenbrook Surgery) took place in November 2014. At the November 2014 inspection the practice was rated as Good.

At this inspection we have rated the practice as good.

At this inspection in December 2017 the key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as Good

We carried out an announced comprehensive inspection at Chiddenbrook Surgery on Wednesday 20 December 2017. We carried out this comprehensive inspection 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.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Clinical audit was used at the practice influenced changes to the care and treatment of patients. For example, the practice had looked at the use of patients with atrial fibrillation (AF) on warfarin (blood thinning medicine) to ensure they had blood clotting test results (INR) within normal range. The results demonstrated a reduction from 23% of patients with poor control to 8% and a subsequent risk reduction of patients developing a stroke.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

Summary of findings

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Patients with diabetes received evidenced based care and services to meet their needs. This included quarterly virtual diabetic clinics held in partnership with colleagues from secondary care and informal education session for all newly diagnosed 'at risk of diabetes' patients. An audit sample of these patients showed better diabetic control.
- The practice had a six monthly link with Queen Elizabeth Community College boarders via the patient group and liaison with pupils via citizenship classes.
- GPs at the practice had acted as trustees, referred to and been proactive in supporting a local charity called 'Upstream' who delivered community-based services for patients who were mentally, physically or socially isolated.

We saw one area of outstanding practice:

- Effective and well embedded systems were in place to proactively share new national guidance, audit findings, clinical data and tools both within and outside of the practice ensuring patients received the most effective care. For example, reception staff had been provided with a detailed triage protocol to assist with non-urgent, routine and emergency presentations, including national guidance regarding the management of suspected sepsis. These included directing patients to a pharmacist, asthma nurse, GP, practice nurse or 999. The document had been recognised as being an effective reference tool and had been shared with other local practices.

The areas where the provider **should** make improvements are:

- Review the method of obtaining patient consent for invasive procedures ensuring it is performed in line with legislation and guidance.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

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

Drs Twomey, Murphy, Braddick, Griffiths, Fearon and Kirwan

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.

Background to Drs Twomey, Murphy, Braddick, Griffiths, Fearon and Kirwan

Chiddenbrook Surgery a GP practice which provides its services under a Personal Medical Service (PMS) contract for approximately 7,179 patients. The practice is situated in Crediton, Devon, a semi-rural area which covers 250 square miles.

Chiddenbrook Surgery is open between Monday and Friday: 8.30am until 12.45pm and 1.45pm until 6pm. Phone calls between 8am and 8.30am and 12.45pm and 1.45pm are answered by the Out of hours message handling service by patients dialling the NHS 111 service. Urgent calls are passed to the GP. Outside of these hours a service is provided by an out of hours health care provider.

The practice offers extended hours two times a week starting from 7.30 am and between 6.30pm and 7.30pm. The days of these extended hours appointments vary and are shared with patients when they contact the practice to book an appointment.

Routine appointments are available daily and are bookable up to three weeks in advance for the GP and a month for the nurse. Urgent appointments are made available on the day and telephone consultations also take place.

The practice population area is in the seventh decile for deprivation. In a score of one to ten, the lower the decile the more deprived an area is. There is a practice age distribution of male and female patients equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 81 years and females living to an average of 86 years.

There is a team of six GPs (three female and three male). Of the six GPs, five are GP partners. Together they provide a whole time equivalent (WTE) of 4.5 GPs. The team of GPs are supported by two registered nurse prescribers, a practice nurse two phlebotomists and two health care assistants. The clinical team are supported by a practice manager and a team of administration and reception staff.

Patients using the practice have access to community staff including community nurses who are based at the adjacent Crediton Hospital. Patients can also access the services of counsellors, podiatrists and midwives at the practice. There is an independent pharmacy on the same site as the practice.

Detailed findings

The practice is a teaching practice for year three medical students.

The GPs provide medical support to four residential care homes and two supported living homes for patients with learning disabilities.

The practice is registered to provide regulated activities which include:

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

Chiddenbrook Surgery

Threshers

Crediton

Devon

EX17 3JJ

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a set of safety policies which were available to staff. Staff received safety information for the practice as part of their induction training. The practice had systems to safeguard children and vulnerable adults from abuse. Systems were on place to ensure policies were reviewed at least annually and were accessible to all staff by using a link on the practice intranet. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- Since the last inspection, the practice manager had reviewed recruitment records to ensure the practice continued to carry out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken for clinical staff and non-clinical staff responsible for chaperone duties. (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).
- All staff had access to up-to-date safeguarding and safety training appropriate to their role. All staff we spoke with knew how to identify and report concerns. Staff who acted as chaperones were trained for the role.
- There was a system to manage infection prevention and control. There was a link nurse who had received appropriate training and had a system in place to perform infection control audits. Each room was done on a rolling monthly basis. Actions included re stocking hand gels, introducing records of cleaning schedules and replacing sharps bins. More in-depth actions, including replacement of furniture were identified as part of ongoing business plans.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. Clinical and electrical equipment had been calibrated within the last 12 months by an external company. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The practice had a buddy system for the GPs to ensure test results and outstanding actions were performed in a GPs absence.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe.
- The practice used a set of templates which were embedded within the computer system. These prompted staff to ask relevant questions and helped record findings of tests and examinations. For example, a template for caring for patients with high blood pressure was used by staff.
- The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters were sent in a timely way and included all of the necessary information.

Safe and appropriate use of medicines

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

Good

Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept both handwritten and printer prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. In addition to normal labelling, prescriptions contained detailed information about the medicine on the box or packet. For example, what the medicine was for.
- The practice had audited antimicrobial prescribing and were performing well compared to local and national practices. For example, data from September 2016 and August 2017 showed that the practice issued 0.78 units compared with the local average of 0.96 and national average of 0.98 units. There was evidence of actions taken to support good antimicrobial stewardship and meet national targets to reduce their overuse. (Antibiotics and antimicrobials both inhibit the growth of or kill microorganisms. Antibiotics are produced naturally from moulds or bacteria. Antimicrobials can be chemically synthesized also, but the term encompasses both).
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. These had been updated in the last year. For example, the last environmental risk assessment had been performed in October 2017. Electrical equipment and clinical equipment had been tested for safety in May 2017. Systems were in place to assess risks regarding fire. The date of the last fire risk assessment was April 2017 and the last fire drill was conducted in November 2016.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, a small number of errors and mis-communications relating to monitoring of patients on blood thinning medicines in the community had resulted in the practice staff working with community nurses to develop a form to help communicate blood results to patients and other healthcare professionals.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. For example, In addition to staff receiving updates of new evidence based guidelines, new National Institute for Health and Care Excellence (NICE) guidelines were presented by a GP during clinical meetings.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used technology and equipment to improve treatment and to support patients' independence. For example, using near patient testing for patients taking blood thinning medicines so that they were able to receive immediate results and have their medicine dosage promptly altered as required.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

GPs at the practice were aware of the recent National Institute for Health and Care Excellence (NICE) guidelines on the recognition, diagnosis and early management of Sepsis (Blood poisoning and septicaemia). The new guidelines had been discussed at a clinical meeting. Reception staff had been provided with written guidance of the red flag signs to recognise sepsis. Staff had access to the local microbiologist for guidance where they were concerned about patient symptoms.

Reception staff were provided with a detailed triage protocol to assist with non-urgent, routine and emergency patient presentations. These included directing patients to a pharmacist, asthma nurse, GP, practice nurse or 999. The document had been recognised as being a useful reference tool and had been shared with other local practices.

Communication systems were used to influence healthcare at the practice. For example, the regular structured clinical meetings were used to cascade information about prescribing, clinical audit findings and QOF data. Additional communication included face to face meetings, instant messaging and emails.

Older people:

- There were 1708 patients over the age of 65 and 687 over the age of 75.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medicines.
- Older people who had problems getting to the practice, who were housebound or were resident in local care homes had their vaccines administered by the GP or practice nurse.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The GPs worked with the rapid access service which assisted keeping patients in their own home environment.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice held a four weekly multi-disciplinary meeting at which the planning and delivery of care to vulnerable patients with complex needs and for those patients approaching end of life, was discussed, planned and co-ordinated.
- The practice was working closely with neighbouring practices, the CCG and community colleagues to develop a health and well-being hub which aimed to provide services to support the older population.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.

Good

Are services effective?

(for example, treatment is effective)

- The nursing team had expertise in the management of asthma, chronic obstructive pulmonary disease and diabetes. They provided individualised care plans. The practice offered patients with diabetes insulin initiation to provide a more local service.
- Patients taking warfarin (blood thinning medicines) were monitored and audited using measurements taken at the practice, saving a journey to the nearest acute hospital.
- In situations where a patient was nearing end of life the practice operated a system where 'just in case bags' were located in the patients home environment to assist with the timely management of their symptoms.
- The practice hosted an IAPT (Improving Access to Psychological Therapy) Counsellor who provided a specific service for people with long-term conditions.

Patients with diabetes received evidenced based care and services to meet their needs. For example:

- The GP and/or Practice Nurse attended quarterly virtual diabetic clinics held in partnership with colleagues from secondary care.
- Patients at risk of developing diabetes were invited to attend group training with the lead nurse and practice manager. These were informal education session for all newly diagnosed 'at risk of diabetes' patients. The one hour session was usually scheduled between 6 and 7pm and included a short presentation explaining how the diagnosis was made, what diabetes is, symptoms and risk factors and how to manage diet and lifestyle to improve outcomes.
- Staff offered local information about exercise opportunities such as walking and talking groups and classes available in village halls and at the local leisure centre. Staff used examples of packaging and foodstuffs to pass around and examine to highlight sugar content to help participants be more aware of what they were buying in support of diabetes management.
- Patients were provided with written information covering the information.

An audit sample of 30 patients from the 285 attendees to the training showed a reduction in blood sugar score demonstrating better diabetic control. Other observations included findings that; patients improved their blood sugar score once they were on the practice register, course attenders tended to improve a lot in the first year but then any improvement was much more gradual, men made the biggest change after the first year and then made marginal gains beyond that and women on average reduced scores more gradually.

Families, children and young people:

- The practice cared for 582 families and had 922 patients under the age of 12 and 1478 under 18 years of age.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates between 2015 and 2016 for the vaccines given were better than the target percentage of 90%. For example, rates ranged between 95.5% and 97%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- There was a quiet space for mothers to feed their baby.
- Patients had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening.
- A fortnightly contraceptive clinic took place for the fitting and removal of interuterine devices and contraceptive implants.
- The practice had a good relationship with the health visitor and school nursing team and were able to access support from children's workers and parenting support groups where relevant.
- The practice had a six monthly link with Queen Elizabeth Community College boarders via the patient group and liaison with pupils via citizenship classes.

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

- The practice's uptake for cervical screening was 81%, which was comparable to the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice provided opportunistic advice to young people on smoking, drugs abuse, chlamydia screening and contraception.

Good

Are services effective?

(for example, treatment is effective)

- The patient participation group at the practice included working age members.
- The practice manager visited a local secondary boarding school a couple of times a year to speak to the head to make sure the practice were working together as well as possible. The practice manager also ran a focus group with the sixth form citizenship students to ask them about how they engage with the services provided by the practice and ways to improve the social media page used by the practice.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances.
- Vulnerable people with health and or social needs were reviewed at the multi-disciplinary team (MDT) meetings to ensure patient safety.
- Patients with learning disabilities were offered an annual health check, using an invitation written in accessible formats according to their identified needs. Staff liaised with the learning disability nurse.
- The practice worked with a community matron who visited any vulnerable patients to assess and facilitate any equipment, mobility or medicine needs they may have and to generally support the patient and their carers.
- GPs worked with the 'Neighbourhood Friends' scheme in the area and were actively working to develop a social prescribing scheme for Crediton.
- Practice staff offered a telephone based recall system which allowed patients an opportunity to discuss any additional medical needs.
- GPs at the practice had acted as trustees, referred to and been proactive in supporting a local charity called 'Upstream' who delivered community-based services for patients who were mentally, physically or socially isolated. The charity provided one to one support to people on a one-to-one basis thereby promoting their health and well being as well as reducing isolation, loneliness and reliance on health and social services. The work had been positively evaluated by the Peninsular Medical School and the University of the West of England.

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

- 87% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable than the local average of 86% and comparable to the national average of 84%. The practice were working with patients and their carers to improve this figure.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is better than the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 92%; CCG 87%; national 91%).
- Patients had access to a counselling service provided by the Depression and Anxiety Service (DAS).
- In house mental health medicine reviews were conducted to ensure safe prescribing and compliance.
- Advice and support was sought as appropriate from the psychiatric team with referrals made for psychiatry review or entry into counselling.
- Systems in place for appropriate blood test monitoring for patients taking high risk mental health medicines.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results showed the practice had achieved 99.9% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%. (QOF is a system intended to improve the quality of general practice and reward good practice). The overall exception reporting rate was lower than local and national averages. For example, the practice had an overall clinical exception rate of 5% compared with the local CCG rate of 11% and national rate of 10%.

Good

Are services effective?

(for example, treatment is effective)

(Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. For example, referral reviews took place to ensure referrals were done in a timely way and were appropriate.

There was a list of completed audit cycles kept at the practice which showed changes to the care and treatment of patients. For example, the practice had looked at a NICE recommendation for patients with atrial fibrillation (AF) on warfarin (blood thinning medicine) to be reviewed to ensure they had blood clotting test results (INR) within normal range. The practice had identified 113 patients with AF on warfarin. The audit identified 77% of these patients were within the correct range for greater than 65% of the time. Action taken following the audit resulted in GPs reviewing patient's treatment options, educating patients on food stuffs which could affect blood clotting and looking at other ways to treat patients. The audit was repeated four months later and found 87 patients with AF taking warfarin. Results showed 92% of these patients were within the correct range for 65% of the time. The results demonstrated a reduction from 23% of patients with poor control to 8% and a subsequent risk reduction of patients developing a stroke.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff. Staff told us there was protected time provided to meet the mandatory training needs. For example, basic life support was offered before the flu season started. Staff added that systems were in place to access 'mop up' training sessions should this training be missed. Records of skills and qualifications were maintained.
- The nurses and GPs demonstrated an understanding of the Mental Capacity Act (MCA) and had received online training. The nurses said they would discuss any concerns with the GPs. MCA was not included as part of the practices mandatory training programme.
- The practice provided staff with ongoing support. This included an induction process, appraisals and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- The GP's and nurses carried out opportunistic health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks including blood tests as appropriate, and reminders to have medicine reviews.

Good

Are services effective?

(for example, treatment is effective)

- The GPs were responsive to change when learning was shared from other healthcare professionals. For example, a GP highlighted a more effective treatment for acne with GPs at the practice. This was communicated with the prescribers at the practice and treatment patterns changed within 24 hours.
- One of the GPs worked with a patient 'summariser' at the practice to ensure an easily accessible electronic summary of a patient's medical history was detailed, obvious and accurate to any healthcare professional using the record.

Consent to care and treatment

The practice obtained consent to care and treatment

- Clinicians understood the requirements of legislation when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent for ear syringes, child immunisations, contraception coils and implants and vaccines appropriately. This was both verbal and written and recorded within the patients' electronic record using templates embedded on the practice computer system. However, for invasive procedures including minor surgery and joint injections, the practice could not evidence that this was in line with current legislation and guidance. For example, ensuring written consent included a record of the discussion with the patient of potential benefits and risks for them.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the five patients we spoke with and eight patient Care Quality Commission comment cards we received were positive about the service experienced. Patients described the service as being excellent, efficient, respectful, and of a high standard. Comments about staff were also positive feedback and remarked on all staff being kind, courteous, professional and helpful.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 221 surveys were sent out and 132 were returned. This represented about 1.8% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 97% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 90%; national average - 85%.
- 98% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 99%; national average - 97%.
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 94%; national average - 91%.
- 92% of patients who responded said they found the receptionists at the practice helpful; CCG - 90%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers by asking during consultations and from information gathered from new patients. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 127 patients as carers (about 1.8% of the practice list). The practice provided a room for regular carers clinics.

Once identified, staff ensured that the various services supporting carers were coordinated and effective.

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

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 consistently higher than local and national averages:

Good

Are services caring?

- 93% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 90% and the national average of 86%.
- 89% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 88%; national average - 82%.
- 99% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 96% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. (For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments).
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered. The GP consulting rooms and majority of treatment rooms were situated on the ground and first floors. There was one treatment room on the first floor. Patients could access this by using the stair lift provided.
- The practice made reasonable adjustments when patients found it hard to access services. There were automatic doors, ramps and grab rails to assist patients with mobility issues.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Overseas travel advice including up-to-date vaccinations and anti-malarial drugs was available from the nursing staff within the practice with additional input from the GP's as required. Patients completed a form, enabling staff to obtain the latest guidelines. Patients were routinely given 30 minute appointments and were given individual plans, appropriate information, education and vaccination. Nursing staff had effective communications with Exeter Travel Clinic where patients could access additional services if required including Yellow Fever Vaccination.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were sometimes able to be reviewed at one appointment.
- The practice held regular meetings with the local community nursing team, palliative care teams and health visiting teams to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including housebound patients living in rural areas and those with a learning disability.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Patients who failed to attend were proactively followed up by a phone call from a GP or nurse.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.
- Appointments could be obtained on the same day, booked up to three weeks in advance for a GP and up to one month for a nurse.
- The practice used a text message reminder service for appointments to reduce 'did not attend' (DNAs) appointments.
- Early morning and evening appointments were available to assist patients not able to access appointments due to their work times. GP, Nurse, HCA and phlebotomy appointments were available during these appointments.
- Patients were able to book GP appointments online.
- There was online access for coded medical records, prescription ordering, address changes available, booking appointments and cancelling appointments.
- 12 monthly repeat dispensing was available for patients where appropriate following a clinical decision.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment were higher than local and national averages. This was supported by observations on the day of inspection and completed comment cards. 221 surveys were sent out and 132 were returned. This represented about 1.8% of the practice population.

- 90% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 94% of patients who responded said they could get through easily to the practice by phone; CCG –82%; national average - 71%.
- 96% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 90%; national average - 84%.
- 93% of patients who responded said their last appointment was convenient; CCG - 88%; national average - 81%.
- 90% of patients who responded described their experience of making an appointment as good; CCG - 82%; national average - 73%.
- 63% of patients who responded said they don't normally have to wait too long to be seen; CCG - 65%; national average - 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Four complaints were received in the last year. We reviewed all of these complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints. There were no trends identified. It acted as a result to improve the quality of care. For example, a complaint regarding miscommunication which resulted in a delay of an ambulance being requested had resulted in the practice liaising with South West Ambulance Trust. An apology was made to the patient and a reminder to staff about following a policy to ensure it is clear who would be requesting an ambulance.

Are services well-led?

Good

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

Our findings

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

The practice was rated as good for well-led because:

- Effective systems and processes were maintained to ensure good governance in accordance with the fundamental standards of care.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. This included succession planning of staff resources for the next five years.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when making and planning changes at the practice and responding to incidents and complaints. For example, staff and patients had been consulted about planned business changes at the practice and had been kept abreast of developments and potential plans.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities and roles of accountability to support good governance and management. For example:

- Clear staffing structures and buddy systems were in place. Staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, safeguarding, prescribing, and infection control.
- An understanding of the performance of the practice was maintained. Clinical meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Lessons were learned following significant events and complaints.
- Recruitment records were well structured and demonstrated pre-employment checks had been carried out.
- Systems were in place to demonstrate environmental risk assessments had been performed.

Are services well-led?

Good

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

- Practice policies, procedures and activities to ensure safety had been kept under review.
- The processes used for monitoring staff training and development had not been monitored. The training matrix was updated on the day of inspection and was completed shortly after the inspection. Systems were in place to address remaining mandatory training gaps.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, fire risk assessments, fire drills, environmental risk assessments and equipment calibration checks.
- The practice had processes to manage current and future performance. Practice leaders had oversight of MHRA alerts, incidents, and complaints and communicated these effectively with the wider staff group.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

- There were 13 friends and family test results received between September 2017 and December 2017. Twelve of the 13 results stated that they would be extremely likely or likely to recommend the practice. The remaining one person gave a neutral response.
- The practice had responded to patient feedback on the friends and family results included concerns relating to unclear guidance on online access. The practice had updated the website to include a hyperlink to the online registration page. The wording had also changed to give clearer guidance. A request for computer access for people who wanted to access their online record had also been actioned.
- The practice manager had met with local sixth form students to seek feedback on services. Feedback included requests for gap year health advice and travel health advice, which was actioned by practice nurses.
- Patient feedback had also influenced the health promotion at the practice. This was publicised on the screen on waiting room displays and local newspaper articles. A request to include pain management had been actioned and was due to take place in early 2018.
- There was an active patient participation group (PPG) who met four times a year. Representatives told us their views were valued and feedback acted upon. They said they had been informed of business developments and consulted regarding patient feedback. Examples of changes included changes in repeat prescription processes, changes to the answer phone message and consultation of changes to the building. The PPG representatives met with other PPGs in the locality to discuss healthcare issues in the wider community.
- The service was transparent, collaborative and open with stakeholders about performance.

Are services well-led?

Good

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

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example, the GPs proactively shared new guidance and tools developed both within and outside of the practice. For example, GPs provided education sessions on all new NICE guidelines and new evidenced based practice.
- The partners recognised the developing need for primary medical services in the area and had been proactive in succession planning. For example, speaking with patients and the PPG about possible future mergers.
- GPs knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example, a receptionists triage document was shared with other local practices.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had used quality development tools to improve systems in the practice. For example, staff were using the 'Productive General Practice' system to improve safe storage and record keeping at the practice.
- GPs at the practice held lead roles both within the practice and externally. For example;

One GP was part of the Mid Devon Healthcare federation board and discussed primary medical services changes in the area. GPs also met with the Town Council to discuss health care needs and were part of the Mid Devon pathology optimisation forum aiming to make pathology services more streamlined, cost effective and of benefit to patients. Other GPs set up and ran the local safeguarding forum and other GPs advised other providers on prescribing issues.

- The practice worked with the wider community and other groups including local charities, the league of friends and other local practices to share knowledge.