Whipton Surgery

Quality Report

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Date of inspection visit: 15/07/2015
Date of publication: 12/11/2015

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?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

We carried out a comprehensive inspection of Whipton Surgery on 15 July 2015. Overall, we rated the practice as good. Specifically, we found the practice to be outstanding for providing caring services and good for providing safe, responsive and effective and well led services.

It was also found to be providing good services across all the patient population groups with the exception of people with long term conditions who received outstanding care.

Our key findings were as follows:

- Staff knew the patients who visited the practice regularly very well, and provided a holistic service which met their needs.
- Feedback from patients was overwhelmingly positive; they told us staff treated them with respect and kindness.
- Patients reported good access to the practice.
- Patients we spoke with told us they felt they had sufficient time during their appointment to explain their health problem and discuss treatment options.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed, and was used to improve patient care.
- The practice was clean and hygienic, and good infection control arrangements were in place.
- There was a clear management structure with approachable leadership. Staff were supported and had opportunities for developing their skills, were well supported and had good training opportunities.
- The practice actively sought feedback from patients and had taken action as a result of what patients had said.

We saw areas of outstanding practice including:

- Twice weekly the practice nurse had protected time to visit patients with long term conditions in their own

Summary of findings

homes, to undertake their annual health review. This enabled patients to be realistically assessed in their own surroundings; reducing the stress, strain and risk of exacerbating their illness by visiting the practice.

- Reception staff were trained to undertake some health checks for patients and were able to provide a flexible service. Staff said they enjoyed the challenge of new learning and were enthusiastic to provide patients with a good service
- The practice nurse performed complex leg ulcer dressings in the practice following extended training. This meant patients were able to receive this complex treatment at the practice avoiding the need to attend the community leg ulcer clinic on the other side of the city. This service was over and above what was expected from the practice in the GP contract and had improved outcomes for patients.
- A home nebuliser service was provided by the practice to help patients retain their independence at home. This was used when a patient known to have respiratory disease had exacerbated symptoms. The GP and nurse visited these patients at home and initiated nebuliser treatment, assessing their suitability to self-medicate using the nebuliser until their symptoms had improved.

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. Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good 

The practice is rated as good for providing effective services. Data showed patient outcomes were commensurate with, or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely to assess and plan patient care, which was then delivered in line with current legislation. This included assessing patient capacity to make decisions about care and treatment and promoting good health. Staff had received training appropriate to their roles; any further learning needs had been identified and appropriate training had been planned. There was evidence of regular appraisals and personal development plans for all staff.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive.

There was a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patient dignity. Relationships between patients (and those close to them) and staff, were professional, yet friendly, caring and supportive. The importance given to the staff-patient relationship demonstrated the high value placed on treating people as individuals, with compassion, kindness, dignity and respect.

Staff were motivated and inspired to offer kind and compassionate care and worked hard to overcome obstacles to achieving this. Services had been developed to promote patient well-being and promote their independence, particularly in relation to those with frailty or longer term conditions. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. The views of the external stakeholders we spoke to were very positive and aligned with our findings.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for patients, which were over and above their contractual obligations. In response to feedback from the patient participation group (PRG), suggestions for improvements had changed the way services were delivered. The practice reviewed the needs of the local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of their choice, this promoted continuity of care. Urgent appointments were available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as a top priority. Staff were clear about their responsibilities and were highly motivated and committed to delivering well-led services.

The practice had a strong leadership approach in championing multi-disciplinary integrated working to ensure patient centred care, improve patient experiences and outcomes. Feedback received from patients and allied health and social care professionals confirmed high standards of care were promoted and responsibility owned by staff.

There was a clear and consistent leadership structure and staff felt supported by management. There was an open, positive and supportive culture. Governance and performance management arrangements were proactively reviewed and took account of current models of best practice.

There was a good level of constructive engagement with staff and a high level of staff satisfaction. Staff had received, regular performance reviews and attended staff meetings and events, new staff had received induction. The practice gathered feedback from patients and had a virtual patient representative group (PRG). The patient representatives were a group of patients who worked together with the practice staff to represent the interests and views of patients so as to improve the service provided.

Summary of findings

Robust systems and good governance was in place to identify and manage risks, and to ensure the service was well managed. The commitment to patient safety, learning and the development of staffs' skills was recognised as essential to ensuring high quality care.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

All older patients had a named GP. Those who spoke with us had been offered regular health checks. The practice had provided care plans for the 2% of their adult patients at most risk of admission to hospital, in accordance with the direct enhanced service (DES) commissioning scheme which mainly encompassed older patients. All patients discharged from hospital were reviewed within 72 hours. Special messages were attached to the computerised patient records that Out of Hours services could view, to communicate important information and ensure consistent care.

The practice attended a virtual ward meeting with other members of the complex care team every six weeks to discuss and consider the care of patients most at risk. The practice also worked in close liaison with the community matron in caring for older patients and their holistic needs. The practice had a palliative care nurse who visited the practice regularly; they were given immediate access to GP's to ensure timely intervention and optimum symptom control for patients nearing the end of life.

People with long term conditions

Outstanding

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

The practice managed the care of their patients with long term conditions effectively. There were recall systems in place which ensured regular reviews of these patients had been carried out.

The Practice Nurse carried out reviews of patients with long term conditions. This included twice a week home visits to those with the most complex needs. A home nebuliser service was provided by the practice. This was used when a patient known to have respiratory disease had exacerbated symptoms and needed further help to breathe. The GP and nurse visited the patient and initiated a nebuliser in their own home. They waited whilst this was in place gave another dose if needed. If the patient was stabilised then the nebuliser was left with them for three or four days to use themselves. All Practice Nurses had received training in undertaking reviews. Practice Nurses attended regular updates to enhance their knowledge and expertise in treating patients with long term conditions.

Summary of findings

The practice provided a leg ulcer complex dressings service. Patients were able to receive this complex treatment as nursing staff had undertaken extra training to acquire specialist skills. This at avoided the need for patients to travel to the community leg ulcer clinic and promoted a holistic approach and improved outcomes for patients.

Families, children and young people

Good

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

Baby and child immunisation programmes were well organised and available to ensure babies and children could access the full range of vaccinations and health screening. These included the eight week check for both mother and baby, along with the immunisation clinics. Last year's performance for child immunisations showed that 100% of one year olds had received all the primary vaccinations required.

Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this.

The practice offered a full range of contraceptive services including emergency contraception. All nurses were trained in cervical screening and attended regular updates. Patients were proactively offered chlamydia screening with self-test kits available in the practice.

There was an alert on the clinical system to identify patients on the child protection register and this was visible to all staff. GP's had all undertaken appropriate child protection training.

The practice worked closely with 'Insight', a service offering counselling for young people who regularly saw patients at the surgery, which was more convenient and familiar for the patient in distress.

Children were always offered an appointment on the day if an urgent appointment was needed. If an ill child attended they would be seen without waiting.

Working age people (including those recently retired and students)

Good

The practice is rated as good for working age people. Advance appointments (up to four weeks in advance) were available for patients to book. The practice offered an online appointment booking service. The practice used a text message reminder service for patients and had used this to communicate with patients about appointments or at short notice. For example, if a GP was off sick. Patients could order their repeat prescriptions online and these

could be sent to a pharmacy of their choice to avoid them needing to attend the practice. The practice actively promoted the repeat dispensing facility to ensure patients had a supply of medicines readily available without having to make a request.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available within the waiting areas.

The staff were proactive in calling patients into the practice for health checks. The practice operated a walk in 'pop up' clinic which enabled patients to call in without an appointment and have routine health checks such as weight, height, and body mass index (BMI) calculations. They also offered health information, and age appropriate screening tests including cholesterol testing

People whose circumstances may make them vulnerable

Good

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

The practice held a register of 32 patients with a learning disability and had carried out annual health checks for 100% of these patients. If necessary the nurse/GP visited the patient at home for this.

The practice had a number of non-English speaking patients. In some cases, family members would attend to translate with the patient's permission, but usually the practice used a telephone language line and a longer appointment was offered to accommodate this. Patients who needed help with language translation were flagged with an alert on the clinical IT system.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Vulnerable patients had been advised how to access various support groups and voluntary organisations. 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 both normal working hours and out-of-hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people living with dementia).

Staff knew how to recognise and manage referrals of patients with more complex health needs and the practice included other health professionals at their practice meetings when required. Patients showing signs of dementia or memory problems were given extra

assistance such as telephone reminders about appointments. Staff were encouraged to be aware of signals that may indicate a change in mental wellbeing, and to raise any concerns should a patient appear dishevelled or forgetful.

Patients on the Dementia register had an alert on the clinical system to advise staff of their diagnosis. GP's were proactive in identifying patients with dementia and use recognised national assessments and referral processes. Families and friends were invited to be actively involved in their care.

Summary of findings

What people who use the service say

All of the seven patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were very helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were largely happy with the appointments system.

We reviewed 36 Care Quality Commission comment cards completed by patients prior to the inspection. All were complimentary about the practice, the staff who worked there and the quality of service and care they provided.

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

Patients said they did not feel rushed during their consultations although waiting times often were longer than 15 minutes. Patients told us they had a good rapport with their GP and felt no improvements were needed. They said GPs always phoned them back when they said they would.

The latest National GP Patient Survey completed in 2014/15 showed patients were satisfied with the services offered at the practice.

The results were:

- 96% of respondents said the last GP they saw or spoke to was good at giving them enough time this compared higher than the local (CCG) result of 91%.
- The proportion of respondents who gave a positive answer to how easy is was to get through to someone at the GP practice on the phone – 87% compared to the local (CCG) average of 84%.
- 72% of respondents said they usually waited 15 minutes or less after their appointment time to be seen compared to the local (CCG) average of 71%
- The percentage of patients rating their experience of making an appointment as good or very good was 87% compared to the local (CCG) average of 83%.

These results were based on 112 surveys returned. We discussed this result and the practice manager said the practice were fully aware of where improvement was needed. The practice was constantly striving to improve patient satisfaction.

Outstanding practice

We saw areas of outstanding practice including:

- Twice weekly the practice nurse had protected time to visit patients with long term conditions in their own homes, to undertake their annual health review. This enabled patients to be realistically assessed in their own surroundings; reducing the stress, strain and risk of exacerbating their illness by visiting the practice.
- Reception staff were trained to undertake some health checks for patients and were able to provide a flexible service. Staff said they enjoyed the challenge of new learning and were enthusiastic to provide patients with a good service
- The practice nurse performed complex leg ulcer dressings in the practice following extended training. This meant patients were able to receive this complex treatment at the practice avoiding the need to attend the community leg ulcer clinic on the other side of the city. This service was over and above what was expected from the practice in the GP contract and had improved outcomes for patients.
- A home nebuliser service was provided by the practice to help patients retain their independence at home. This was used when a patient known to have respiratory disease had exacerbated symptoms. The GP and nurse visited these patients at home and initiated nebuliser treatment, assessing their suitability to self-medicate using the nebuliser until their symptoms had improved.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Whipton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a nurse specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to Whipton Surgery

Whipton Surgery was inspected on Wednesday 15 July 2015. This was a comprehensive inspection.

Whipton Surgery provides GP primary care services to approximately 4000 people living in and around the area of Whipton on the outskirts of Exeter city.

There are three GP partners, one male and two female and one female salaried GP. The practice has been registered as a GP teaching and training practice for 10 years. There are two GP trainers, who are also tutors for medical students. The practice provides training opportunities to doctors seeking to become qualified GPs.

The team were supported by a practice manager, a practice nurse, one advanced health care assistant (HCA) and one phlebotomist. The clinical team were supported by additional reception and administration staff.

Patients using the practice also had access to community staff including community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open between 8.30am and 6pm every day but Wednesday. The practice offers appointments on Monday, Tuesday, Thursday and Friday, between the hours of 8.30am and 5.30pm, and on Wednesday appointments are available between 8.30am and 12 midday. On

Wednesday afternoon the surgery reception is open for patients to call in and make appointments but the phones are switched over to Devon Doctors the Out of Hours provider. Minor operations and nurse clinics are held on Wednesday afternoon. The practice operates a 'phone on the day' appointment system for 70% of GP appointments; 30% of appointments are pre-bookable up to six months in advance. Extended hours were offered on a flexible basis. The GPs at the practice often fitted patients in after 6pm in the evening and before 8am in the morning if they were unable to attend during core hours.

Outside of the above opening hours the practice directed patients to Devon Doctors the Out-of-Hours service.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before conducting our announced inspection of Whipton Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local NEW Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on 15th July 2015. We spoke with seven patients, three GPs, two of the nursing team, the practice manager and members of the reception and administration team. We collected 36 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

The practice had a well-established, comprehensive safety system which used a range of information to identify risks and improve quality in relation to patient safety. Staff we spoke with were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. We reviewed safety records, incident reports and minutes of meetings. These showed the practice had managed these consistently over time and so could demonstrate a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of nine significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were discussed as they happened and reviewed as necessary at the practice meetings. There was evidence from discussion with GPs and nurses that the practice had learned from events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and felt encouraged to do so. For example an anonymous complaint was made about not being able to get an appointment for an un-well baby. The practice took immediate steps to fully investigate. Actions were put into place to prevent any reoccurrence and this was shared with other members of the multi-disciplinary team.

National patient safety alerts were disseminated by the practice manager or GPs to practice staff by email or memo. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, there was a recall on a specific type of speculum (equipment used for cervical smears). The staff responded immediately and an alternative supplier was found in the interim period until new stock was sent out.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. Training records showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information and record safeguarding concerns. They knew how to contact the relevant agencies in working hours and outside of these hours. The safeguarding policies contained contact details for staff to refer to. The practice had appointed a specific GP as the safeguarding lead for vulnerable adults and children, who had been trained to the required level three in child protection. All the staff we spoke with were aware of who the lead was and who to speak to if they had a safeguarding concern.

There was a system in place to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. A register of vulnerable adults and children with a child protection plan was overseen by the GP safeguarding lead. The register and records from meetings demonstrated good liaison with allied professionals such as health visitors, community psychiatric nurses and palliative care nurses.

Staff followed a chaperone policy (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Guidance and notices were displayed in the waiting room and consulting rooms informing patients of their right to have a chaperone present during consultation. Only clinical staff acted as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures. The procedure described the action to take in the event of a breach of these temperatures. The fridge temperature was checked and documented twice daily, confirming the appropriate temperature range had been maintained. The practice nurse was responsible for and had ensured that medicines were in stock and within their expiry dates. Vaccines were

checked weekly for their expiry dates and rotated so that vaccines closest to their expiration date would be used first. Expired and unwanted medicines had been disposed of in line with waste regulations. Vaccines were administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance.

The practice followed a protocol for repeat prescribing which was in line with national guidance, complied with the legal framework and covered all required areas, including training for staff who generated prescriptions and how changes to patients' repeat medicines were managed. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice nurse was the nominated person responsible for infection prevention and control. All staff received induction training about infection control specific to their role and received annual updates. An infection control audit had been undertaken in December 2014 which identified that all areas were well managed and no new issues were found.

An infection control policy and supporting procedures were available, which enabled staff to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff we spoke with described how they would use these in order to comply with the practice's infection control policies. There was also a policy for needle stick injuries. Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw that sharp bins were available along with bins for the disposal of both ordinary and clinical waste, which had lids and foot operated pedals. There was a contract in place for the removal of all household, clinical and sharps waste and waste was removed by an approved contractor.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records confirmed that all equipment had been tested in June 2015 and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date (June 2015). We saw evidence of calibration of equipment; for example, weighing scales and blood pressure monitoring equipment.

Staffing and recruitment

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. They told us about the arrangements for planning and monitoring the number and mix of staff to meet patients' needs.

The practice had a recruitment policy. We looked at records relating to the most recently recruited clinical and administrative staff. We found appropriate pre-employment checks such as obtaining references and a criminal record check through the Disclosure and Barring Service (DBS) had been carried out. The practice had arrangements in place to assure them that the clinical staffs' professional registrations were up to date with the relevant professional bodies and that the required staff had medical indemnity insurance in place.

Monitoring safety and responding to risk

The practice had a variety of systems, processes and policies which were used to manage and monitor risks to patients, staff and visitors to the practice. These risks included dealing with emergencies such as a fire or someone becoming seriously ill at the practice. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice had undertaken a health and safety risk assessment.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. The practice had arrangements in place to manage emergencies. We saw a fire risk assessment had been undertaken. Staff told us that the fire alarms were tested weekly. We saw records confirming annual staff training for fire safety.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support at the required time. Emergency equipment appropriate for children and adults was available, including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked staff, they knew the location of this equipment and records confirmed it was checked regularly. Emergency medicines were available in various secure areas of the practice. These included those for the treatment of cardiac arrest, anaphylaxis (a severe allergic reaction) and hypoglycaemia (very low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place, which staff were aware of, to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, incapacity of staff, unplanned sickness and flooding. The practice had carried out a fire risk assessment.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients had their needs assessed and their care planned and delivered in line with published guidance, standards and best practice such as those published by the National Institute for Health and Care Excellence (NICE) and those from their local commissioners.

Minutes of clinical and practice meetings confirmed that new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain and update their knowledge. Patients were appropriately referred to secondary and community care services. These patients were discussed during clinical meetings. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches.

A coding system (read coding) was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improved patient care by ensuring clinician's based their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

The practice nurse and health care assistants helped to manage patients with clinical conditions such as diabetes or asthma. The opportunity, during regular assessments of patients over the age of 55 years, was taken to proactively check for other symptoms, for example patients were asked if they had any memory problems. Any issues were then monitored and advice was given when appropriate.

There was no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were referred on need, and that age, gender, race and disability were not used as an adverse influence for decision-making. Patients could request to be seen by a male or female GP.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by named members of staff and used to support the practice to carry out clinical audits. The practice sent us five clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, a clotting screen audit was undertaken to ascertain the cost and appropriateness of these tests and to see if the results were acted upon correctly. The results were favourable and showed the practice managed this well. However it also showed how some financial saving could be made by better management in the future.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, an audit was undertaken for those patients being prescribed a particular drug. This was a controlled drug which can be initiated by secondary care for the management of Attention Deficit Hyperactivity Disorder (ADHD). This audit considered if patients had been followed up by secondary care at six monthly intervals as recommended by NICE guidelines, if patients were having six monthly height, weight and blood pressure readings recorded and if prescriptions were given for a maximum of 28 days at a time. The audit identified one patient whose treatment needed a review from secondary care but the patient had failed to attend. Actions were put in place to allow the patient to attend the practice for their review which was less stressful for them. It was also recommended that when a review had been completed by secondary care the patient records must be updated and in addition an alert used to indicate the next date for review, so that patients who had fallen outside guidelines could be easily identified.

Good

Are services effective?

(for example, treatment is effective)

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check that patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had followed the gold standards framework for end of life care. A palliative care register and regular internal as well as fortnightly multidisciplinary meetings were used to discuss the care and support needs of patients and their families.

The practice kept a register of patients identified as being at high risk of admission to hospital and of vulnerable patients, so staff could promptly recognise them and fast track any appointment or prescription request if necessary. Structured annual medicine reviews were also undertaken for patients with long term conditions. For example, 17 out of the 21 patients (89%) with dementia had received a review.

The practice participated in local benchmarking run by the local Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

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

A supportive and positive culture was evident throughout our inspection. All the staff described the practice as a good team who supported each other well. All clinical staff undertook annual appraisals which identified learning needs and the practice was proactive in arranging training. For example the nurse told us they hoped to undertake the nurse mentor / trainer qualification which is a year's course, they told us the practice had supported them with their application and they were hopeful to gain a place. Nursing staff at the practice had defined roles and were able to demonstrate they were trained to fulfil them, for example wound care.

Administration staff were trained and experienced with most having worked at the practice for many years. They all said they felt well supported and were listened to when concerns were raised. Three reception staff had been trained to undertake further roles. One was a qualified phlebotomist (a person who takes blood samples) two others were trained to run the 'pop-in' clinic with the practice nurse and health care assistant, taking blood pressures, height, weight, body mass index (BMI) and cholesterol testing. They told us they enjoyed the dual roles and that they were well supported and encouraged with all aspects of training.

Working with colleagues and other services

The practice worked effectively with other service providers to manage patients with complex needs. Blood test results, X ray results, and letters from the local hospital including discharge summaries, out of hours GP reports, and the 111 service summaries were received electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Pathology results, OOH reports and 111 summaries were all seen and actioned by a GP on the day they were received. We saw that where the GP expected urgent results to arrive when the practice was closed, information regarding the patient was uploaded onto the OOH system to enable the OOH GPs to manage the results.

Discharge summaries and letters from outpatients were seen by a GP and usually actioned on the day of receipt

Good

Are services effective?

(for example, treatment is effective)

and all within five days of receipt. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice held virtual ward meetings every six weeks to discuss patients with complex needs, such as those with multiple long term conditions, mental health problems, or patients from vulnerable groups or those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with OOH providers and other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate effectively with other providers. For example, there was a shared system with the local GP Out-of-Hours provider to enable patient data to be shared in a secure and timely manner.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made.

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets and posters about local services were available in the waiting area. The practice produced quarterly newsletters which gave practical advice to patients on topics such as minor ailments and dietary facts, one patient told us they found them useful.

Consent to care and treatment

Staff referred to Gillick competency when assessing a young (under 16 years old) patient's ability to understand and consent to treatment without parental consent. Staff were able to describe how they assessed a patient's capacity to consent in-line with the Mental Capacity Act 2005, with guidance available in the Mental Capacity Act policy and consent policy. A pathway was in place to enable appropriate referrals and support integrated care for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held quarterly with other health and social care providers. Individual cases were discussed regularly between clinical staff to optimise care for patients and relatives regarding their physical and emotional needs. For patients approaching the end of life care plans were in place, for others their wishes were recorded and reviewed by the lead GP, with changes communicated and shared with Out of Hours providers.

The practice used templates for documenting consent for specific interventions. For example, for childhood vaccinations verbal consent was documented in the child's electronic patient notes with a record of who gave consent and who was present at the appointment. Written consent was obtained for minor surgery procedures where the relevant risks, benefits and possible complications of the procedure were explained.

Health promotion and prevention

New patients registering with the practice were offered a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering every opportunity for chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Health promotion literature was readily available to patients and was up to date. This included information about support services, for instance, smoking cessation schemes. The practice had the highest success rate in the area compared to other practices with a success rate of 51.2% per 1000 patients who had stopped smoking.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. Reception

Good

Are services effective?

(for example, treatment is effective)

staff were trained to undertake some health checks for patients and were able to provide a flexible service. Staff said they enjoyed the challenge of new learning and were enthusiastic to provide patients with a good service.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice's performance for cervical smear uptake was 83%, which was better than the national average of 81.9%; the practice audited patients who did not attend and there was a policy to offer telephone reminders.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2015 national patient survey which showed responses up were consistently better than local and national averages. The evidence showed patients were very satisfied and confirmed they were treated with compassion, dignity and respect. Data showed that 92% of respondents said that their overall experience was good or very good. These results were above the regional Clinical Commissioning Group (CCG) average of 91% and the national average of 85%. The practice was above average for satisfaction scores on consultations with GPs and nurses: 95% of respondents said the GP was good at listening to them, which was above the CCG regional average of 92% and the national average of 89%. Ninety-nine per cent of respondents said they had confidence and trust in the practice nurse, which was above the regional CCG average of 98% and the national average of 97%.

We looked at the results of the Family and Friends test for May 2015 which asked patients whether they would recommend their GP practice to their friends and family if they needed similar care or treatment; 100% of respondents said they would recommend this practice.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 36 completed cards and all were positive about the service experienced. All patients said they felt the practice staff were helpful, caring, supportive and friendly. They said staff treated them with kindness, dignity and respect. We also spoke with seven patients on the day of our inspection. All of these patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The GPs came to the waiting room to greet patients rather than use an electronic calling system. They told us they did this to ensure a personalised and welcoming service for all of their patients.

Patients described the practice as caring, respectful, exceptional, efficient and outstanding. Staff had gone above and beyond expectations and the examples below demonstrate the caring approach taken in response to patients and their families.

- A GP arranged joint assessments for a patient living with dementia, supported by their daughter and the community psychiatric nurse (CPN), the assessment was carried out at the patient's home rather than in hospital or at the practice – this had helped the patient to be less unsettled and the CPN supported this caring approach.
- The practice organised a dietician to talk to patients to promote good health and lifestyle choices and had also enlisted a supermarket to provide food samples for diabetic patients.
- A patient accompanied a relative to an appointment but didn't appear well themselves. The staff alerted this to the GP and at the end of the original consultation the GP then treated the relative. This resulted in a hospital referral.
- The practice nurse undertook a flu vaccination clinic at the nearby tower block of flats. This was to prevent people from having to cross the busy main road to attend the practice.
- Two days per week the practice nurse visited patients as part of their chronic disease management in their own homes. This was to done for their comfort so that they did not have to visit the practice and exacerbate their symptoms.
- The practice nurse undertook phone consultations for smoking cessation to an agoraphobic patient; phoned a patient with a learning disability weekly to give reassurance and make sure they were taking their insulin; visited a patient with a leg ulcer over a two week period as the district nurses' caseload was overloaded due to staff shortages; delivered catheter supplies for a gentleman at home who had undergone emergency catheterisation during the night and was left with no supplies; and was caring for his dependent, elderly wife.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation and treatment room doors were closed during consultations and conversations that took place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The waiting room and reception desk were separate rooms. This prevented patients from overhearing

potentially private conversations between patients and reception staff. If a patient wished to speak to a receptionist in private, receptionists told us they took patients to a private room.

Care planning and involvement in decisions about care and treatment

The patients we spoke with told us their diagnosis and proposed treatment options that were explained to them. They spoke of feeling reassured and safe in the care of the clinical team. Patients told us they felt involved in their care and treatment decisions. These views aligned with the findings of the most recent national GP patient survey results, which found 91% of respondents had confidence and trust in the last GP they saw or spoke to and were good at involving them in decisions about their care, this was higher than the CCG average of 87% and the national average of 81%.

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to understand treatment options and give their consent. They had recorded best interest decisions, consulted carers who had legal authority to make healthcare decisions on behalf of the patient, and sought specialist advice if needed.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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 patents this service was available.

The practice nurses and GPs ensured that all care home patients registered at the practice had up to date care plans. We saw evidence that these were in place and regularly reviewed. Patients living with dementia and their carers and/or advocates were involved in the development of their planned care, involvement in agreeing these and patients where appropriate were offered information about end of life care planning. Joint home visits were undertaken by the GPs and practice nurse when needed and involved other professionals such as the palliative care nurse and the family and carers when appropriate. The practice ensured they held at least six weekly multi-disciplinary meetings with other health and social care professionals for patients with complex needs, end of life care planning and for palliative care.

Patient/carer support to cope emotionally with care and treatment

We looked at 36 Care Quality Commission comments cards that had been completed and spoke with seven patients. All comments were positive. Patients stated that they were pleased with the service, were treated with respect and said that the GPs went above and beyond what was required to make sure the care offered was appropriate. Patients said they always had enough time to discuss their problems and could make longer appointments if they needed them.

Notices in the patient waiting room and on the website 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. Information was sent to carers and was available to them in the practice to ensure they understood the various avenues of support available to them. The practice made referrals, with the patients consent, to local support groups such as Age Concern. The practice had a system in place to support patients known to them who had suffered a recent bereavement.

There was information on what to do in times of bereavement and patients we spoke with told us they felt supported through all emotional circumstances. The national GP patient survey showed that 96% of patients said they were given enough time during their appointment to talk through their concerns this was higher than the local average of 91% and the national average of 87%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the patient population were identified, understood, and used to inform the way services were delivered. We saw evidence that the practice management team involved the patient participation group (PPG) in the development of their patient survey and action plans in response to the feedback received.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the practice nurse to receive their influenza vaccinations. All the practice staff pro-actively followed up information received about vulnerable patients. GPs used their consultation time proactively, for example offering to undertake a cervical smear at the time of the consultation instead of asking the patient to come back and see the nurse. An audit showed this practice had improved the cervical smear uptake.

Tackling inequity and promoting equality

The practice had recognised the needs of different patient groups in the planning of its services. For example, double appointment times were available for patients with learning disabilities to ensure patients were not compromised by lack of time. The majority of patients were English speaking, but access to online and telephone translation services were available as required.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a waiting area with space for wheelchairs and prams. This helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice offered appointments on four full days per week and one half day. On Monday mornings a GP triaged all patients who telephoned for an appointment in order to prioritise those with the most urgent needs. The practice operated a 'phone on the day' appointment system for 70% of GP appointments; 30% of appointments were pre-bookable up to six months in advance. Extended hours were offered on a flexible basis. The GPs at the practice often fitted patients in after 6pm in the evening and before 8am in the morning if they were unable to attend during core hours. For example a patient needed an appointment with the GP but worked in North Devon and was finding it difficult to obtain an appointment, the GP arranged to come in early to see the patient at 8am. A patient visited the surgery on a busy Wednesday morning to make an appointment with the nurse. No appointments were available so the health care assistant agreed to see them during their coffee break. Data showed that in the last twelve months 45 appointments were made out of core hours including some on a Saturday morning.

Following feedback from the annual patient satisfaction survey the practice set up a pilot 'pop-in' clinic to address the length of time it takes patients to get an appointment. The clinic was operational during normal opening hours. Patients did not need an appointment to attend. Data showed that 82 patients in the initial four months used the service. The implementation of this service had saved appointment time and given patients another access route to services. It was planned to develop the service further by offering initial dementia checks to eligible patients and general healthy lifestyle advice.

Comprehensive information was available to patients about appointments in the practice waiting room. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the Out-of-Hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available to ensure that older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions, in particular were given enough time. This also included appointments with a named GP or nurse.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 80% were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 78% and national average of 75%.
- 87% described their experience of making an appointment as good compared to the CCG average of 83% and national average of 73%.
- 72% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 71% and national average of 65%.
- 87% said they could get through easily to the surgery by phone compared to the CCG average of 84% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated member of staff who handled all complaints in the practice.

We saw in the waiting room that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. The practice had not received any formal complaints in the last 12 months. However, complaints had been received in previous years and we saw they had been handled appropriately and where the outcomes had been shared with staff for future learning.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to support patients and to provide a high quality service delivered in a friendly and caring manner. Their vision was

- To maintain longstanding traditions with a practice team and environment which is welcoming, caring and accessible for all patients
- To treat patients fairly and equally, and with dignity and respect
- To provide highly effective, efficient and safe healthcare services
- To listen, communicate and collaborate with patients effectively

The team culture and behaviours reflected this. The practice strategy was reviewed regularly by the partners. The GP partners worked well together to develop short and long term planning. The practice was aware of future NHS developments and any pressures which might affect the quality or range of service and was forward thinking in identifying ways to manage their impact. For example how weekend GP provision would impact on the practice. There was constructive engagement with staff and a high level of staff satisfaction.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available to staff on the practice computer system. We spoke with clinical and non-clinical staff, all of whom knew where to find these policies. We looked at a sample of policies and procedures; they were up to date and had a date for review. There was a process in place for new or reviewed policies to be agreed before being implemented.

The practice staff discussed patients and services daily. They were able to instantly review the practice's management of a patient's condition if a problem or near miss was identified. The coding of diagnosis and recording of medicines meant that searches could instantly identify if a problem existed. Information sharing across teams was given a high priority. Every patient referral that was made was read by another GP in the practice to check and discuss if needed. There was protected time each week for the GPs and practice manager to meet to discuss weekly issues and strategic decisions. The practice manager met with the administrative staff daily to inform them of any changes needed. There were multi-disciplinary meetings (MDT) every eight weeks and GP partner meetings were held weekly. We saw minutes of these meetings and these were shared with the appropriate staff and in a timely manner.

The practice had comprehensive assurance systems and performance measures, which were reported and monitored. They had protocols in place for chronic disease management which were regularly reviewed and updated according to local clinical commissioning group (CCG) and National Institute for Health and Care Excellence (NICE) guidelines. The QOF data showed the practice was performing above the averages of the local CCG and across England as a whole. Performance in these areas was monitored by the practice manager and GPs.

There was a systematic programme of clinical and internal audit, which was used to monitor quality and identify where action was needed. The practice had completed a number of clinical audits in the last year, the results of which demonstrated outcomes for patients had improved. There were comprehensive arrangements for identifying, recording and managing risks, issues and mitigating actions. Incident reporting was encouraged and was reviewed every six weeks at all levels across the practice.

Leadership, openness and transparency

The GP partners upheld a visible profile in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We were given written feedback from five locum GPs who have worked or were still working at Whipton Surgery. All were extremely positive and complimentary of their working experience there. All five described how they were included as part of the team and were involved in all meetings and learning opportunities.

We were given written information from other healthcare professionals in the community who were complimentary

Are services well-led?

Good

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

about Whipton Surgery. All commented that they were always able to speak to the practice staff in a timely manner and all said the practice was supportive and helpful at all times.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the GP partners.

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

The practice had gathered feedback from patients through patient surveys and compliments. We looked at the results of the 2014 annual national GP patient survey to which 113 patients had responded. High levels of satisfaction were seen in the responses to the national GP patient survey. Access to the practice was very good and patients could see a GP quickly. 94% of patients reported that the last time they got an appointment it was convenient to them, this compared slightly higher than the national average of 92%.

The practice had a small active virtual patient representative group (PRG) which had a membership of approximately six patients. The practice continually advertised for PRG members on the practice website, they also added a note to prescriptions and asked patients at the practice, to encourage new members. New patients registering were given information about the PRG and directed to the website. The group communicated with each other via email or by meeting up. The practice reviewed patient feedback supplied via the PRG quarterly. The practice also reviewed feedback from other sources including comments made on NHS Choices website, Friends and Family results and patient survey results.

The practice manager showed us how analysis of the GP patient survey took place. The survey was discussed and actions taken to make improvements for example, to improve the appointment system a host of actions were identified and implemented. These included easier access to book and cancel appointments, the introduction of a 'pop in' clinic for patients who wanted blood pressure checks, urine testing, or lifestyle and smoking cessation advice. Other improvements were made to improve patient care including improvements to telephone access by increasing staff numbers at busy times and improving the appointment system.

There was a low turnover of staff at the practice. Staff said they felt their views were valued and they felt listened to. Management valued their staff and gave them rewards to show their appreciation. For example every December the staff had a paid shopping day extra to their annual leave allowance. The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. There was an open culture and staff told us they did not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Minutes of all the meetings we reviewed showed there was a clear process of reporting progress back to staff and linking issues across the whole team.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. The practice had reviewed their referrals for patients who may have cancer, to see if they could take any learning from the outcomes. Data showed that 100% of patients had been seen within the required two weeks. Bi monthly clinical update meetings reviewed QOF disease groups, protocols were checked and new guidelines discussed. The practice manager met regularly with other practice managers in the area and shared learning and experiences from these meetings with colleagues. GPs met with colleagues at locality and clinical commissioning group meetings, attended learning events and shared information from these with the other GPs in the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They commented positively on the clinical support they could easily obtain from the GPs and each other. All the staff we spoke with told us they had had an appraisal in the previous 12 months and records we saw supported this. Clinical staff told us that they attended external clinical and peer support meetings. Learning from these meetings was shared at the weekly clinical meetings.

Training needs were identified throughout the year as roles developed and also at appraisals. Staff were also

Are services well-led?

Good

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

encouraged to ask for specific training. For example the practice nurse completed a year-long cancer care course. They were now qualified to discuss end of life care with patients and provide them with the support they needed.

The practice organised in-house training for example in venepuncture and blood pressure monitoring etc. For the more specialist areas outside trainers visited the practice and delivered a group session, for example dementia awareness. The practice also paid for staff to attend specific courses related to their individual roles for example in medical terminology, summarising, NHS health checks, smoking cessation. When the sessions were held at the practice another health provider manned the phones and locum reception cover was arranged. The practice never closed their doors when training sessions were being undertaken as patient access was paramount. Some staff had shadowed the district nursing team and the community matron to understand their roles and to ensure good communication continued. They also visited neighbouring practices and local pharmacies to see how they operated and shared good practice. One staff member was going to the direct referral service offices to see how the 'choose & book' system worked. All individual training was shared with the whole team to enable others to benefit.

The practice was a teaching practice with a strong track record and commitment to training new GPs. The practice had received funding from the Department of Health's Multi-Professional Education and Learning fund, which helped them to redevelop the practice and provide enhanced facilities for GP trainees. For the last six years a GP partner had also been a Training Programme Director for the Exeter GP vocational training scheme and with two other colleagues, organised and delivered teaching to over 60 GP trainees every week. They also visited other GP practices to approve them as training practices. This experience was used to gain insight into what other practices were doing and share ideas and good practice.

The practice had excellent feedback from trainees about their experience at The Whipton Surgery. We saw excellent feedback from patients about the trainees in the patient satisfaction questionnaires. Trainees were supported to undertake projects which would improve patient care. For example an audit was undertaken of the numbers of patients that did not attend the practice for their appointment. An audit showed that it was the most vulnerable patients including those who were depressed or those with drug and alcohol related problems that did not attend. As a result of this audit a text messaging reminder service was introduced. Repeat audits showed this had improved attendance.

The practice had completed reviews of significant events and other incidents and shared findings with staff both informally and formally at meetings to ensure the practice improved outcomes for patients. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. The results of feedback from patients, through the patient participation group, patient feedback board, family and friends test, were also used to improve the quality of services.