Foxhayes Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Foxhayes Practice was inspected on Friday 14 November 2014. This was a comprehensive inspection.

Foxhayes Practice provides primary medical services to people living in the city of Exeter and surrounding villages in Devon covering approximately 50 square miles. The practice provides primary medical services to a diverse population and supports patients living in four adult social care homes in the area. At the time of our inspection there were 3633 patients registered at the service. The practice has a higher percentage of younger patients under 55 years compared with the majority of practices in the city of Exeter.

The practice is unusual in that it was established ten years ago by two full time partners; one a GP (male) and the other an Advanced Nurse Practitioner (female) . The practice also has a female salaried GP, two female nurses, one of whom is a nurse practitioner and a female health care assistant. Foxhayes is a training practice, with a GP partner approved to provide vocational training for GPs, second year post qualification doctors and medical students.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice is rated as outstanding.

Our key findings were as follows:

- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Patients said they felt safe.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The practice had a very good skill mix which included two advanced nurse practitioners (ANPs) and was able to see a broader range of patients than the practice nurses.
- The practice was well equipped to treat patients and meet their needs.

Summary of findings

- There was a strong leadership structure and staff felt supported by management.
- Patients were involved from the outset in the development of the practice values and on-going projects to improve the service. Patients had an equal say in the mission statement of the practice which highlighted that they should be treated with dignity & respect, for example have a voice in all decisions about their own and their family care.
- There was high patient involvement at Foxhayes practice. Patients were consulted through the virtual PPG (100 patients) and face to face meetings with representatives from the 'Friends of Foxhayes practice. Their suggestions had developed into work streams to implement changes at the practice. There were many examples of these between 2006 and 2014 and included involving patients in the recruitment process and patient ownership of the practice newsletter.

We saw areas of outstanding practice:

- The practice was caring and extremely patient centred. Eight patients we spoke with and 24 in comment cards confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. The mission statement was developed and reviewed with patients. New patients were welcomed personally with a letter and one to one introduction. During the year, 32 patients in vulnerable circumstances had been give support through the practice taxi fund.
- The practice understood the needs of the entire patient list and had developed a responsive service accordingly. For example, early morning appointments were available twice a week and extended opening available one evening per week. The text messaging service had been extended to improve outcomes for patients with long term conditions. The patient list was managed in a way to avoid any barriers.,
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice worked collaboratively with a larger GP practice situated close by to provide access to comprehensive midwifery services for young pregnant mothers. The practice had a successful, active carers support group which provided a social, network and support for isolated and vulnerable patients. The co-ordinator had a team of volunteers who offered services including telephone support, a sitting and befriending service, social events and excursions and health promotion events. Patients at the practice also had an allotment club, which provided opportunities for vulnerable people to build networks within the community. There was a high incidence of patients registered at the practice with substance misuse problems who wished to change their lifestyle. The GP partner had completed additional training and was a qualified pharmacist so had the skills and experience to safely manage the detoxification process for suitable patients living in the community. He did this in conjunction with specialist agencies who provided further support for the patients. This facilitated continuity of care for patients in such situations.

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.

Systems and processes demonstrated that the practice was safe. There was an open culture in which staff understood and fulfilled their responsibilities to raise concerns, and to 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.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. Foxhayes is a teaching practice. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG and leading to positive outcomes for patients registered there. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice specifically targeted at risk groups for health screening, support and treatment. Data also showed there was a low percentage of emergency admissions and attendance at A & E of patients registered at the practice. Medicines were constantly reviewed for patients so that prescribing followed guidelines and was efficient and effective.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

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 patient-centred culture, for example the practice mission statement had been developed and was reviewed with patients. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Patients were encouraged to use first name terms for staff, which promoted a caring culture at the practice. New patients told us they were made to feel welcome from the outset, when the GP partner came to meet them and introduce them to staff at the practice.

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We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. For example, patients felt that the practice should adopt a non uniform policy for the staff as uniforms were felt to be a barrier to building a rapport. The practice had achieved a national carers award for the support provided to carers. The views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

There was a high incidence of patients registered at the practice with substance misuse problems who wished to change their lifestyle. Additional staff training to extend skills meant patients experienced continuity of care because the practice was able to manage the detoxification process safely supported by other agencies.

The practice was a member of the Exeter locality at the CCG and had raised awareness of key priorities and developments for patients at the practice. The practice website had information for patients about service improvements and how this linked with the whole area plans for transformation of health and social care.

Access and flexible appointments were available. Patients had access to 15 minute or longer appointments or longer if needed. Staff demonstrated sensitivity towards patient mental health needs and booked appointments at quieter times of the day. The practice had an online appointment booking system and appointments were available before the main surgery times twice a week. Telephone appointments were available and the practice remained open to patients over the lunchtime period between appointment sessions. The practice also had extended opening every Tuesday evening until 8pm to avoid disruption for working patients. A PPG member told us discussions were underway about offering appointments at the weekend and the practice was working to set this up. Negotiations were underway to run late night clinics for patients with complex long term health conditions so their health could be monitored. Patients with type one diabetes requiring treatment with insulin would be targeted for this new planned service.

A large proportion of patients registered were students attending the local university living in rented accommodation. Staff told us that the practice policy enabled patients to stay registered for continuity of care even if they moved to another part of Exeter. Information held by the practice meant that the team had a good overview of patients living in vulnerable circumstances. The practice was taking part in a pilot to test an assessment system which

Summary of findings

flagged vulnerability in individual records and included social networks. There were no barriers to registering with the practice, including those with no fixed abode. The practice worked closely with a neighbouring practice which specialised in primary medical services for people who were vulnerable due to their housing situation and had complex mental health needs including substance misuse.

Patients were closely involved in looking for alternative accessible practice premises which could be adapted.

Foxhayes was exceeding the practice requirement for appointments. For example, over a period of 10 days between 10 – 21 November, 669 appointments were provided for 3633 patients registered. The national average for appointment availability is 70 per 1000 registered patients, so Foxhayes would be expected to provide a minimum of 280 appointments.

Home visits were made to a local nursing home on a specific day each week, by a named GP and to those patients who needed one. We looked at the overall figures for the number of patient appointments provided in November 2014, again these exceed what was expected of this small practice.

The practice worked collaboratively with a larger GP practice situated very close to Foxhayes to provide access to comprehensive midwifery services for young pregnant mothers.

Are services well-led?

Good

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

The culture of the practice was focussed primarily on patient experience. Learning and implementing change to improve the quality of care and treatment for patients was actively promoted. Patients were involved from the outset in the development of the practice values and on-going projects to improve the service. Patients had an equal say in the mission statement of the practice which highlighted that they should be treated with dignity & respect, for example have a voice in all decisions about their own and their family care. Patients were consulted through the virtual PPG (100 patients) and face to face meetings with representatives from the 'Friends of Foxhayes practice. Their suggestions had developed into work streams to implement changes at the practice. There were many examples of these and included involving patients in the recruitment process and patient ownership of the practice newsletter.

Summary of findings

There was a team approach with a scheme of delegation to review policies and procedures. An area we highlighted that could be improved was to increase business and governance awareness through formalised meetings between the partners at the practice.

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.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had a list of carers and provided additional support for them through a link community worker as well as health checks. This work had been recognised and the nurse partner had achieved a national carers award for these achievements.

People with long term conditions

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. For example, the practice worked in conjuction with a nearby practice to provide a specialised service for young mothers. Data showed that the practice was better than expected with regard to chlamydia screening.

Families, children and young people

Good

The practice is rated as good for the care of working age people, in particular students registered at the practice.

The practice had analysed the needs of the total population registered with them and identified a high percentage of patients were students at the local university and college. Patients lived in temporary rented accommodation, which could mean they moved to a totally different part of the city. The practice promoted continuity of care and had a policy allowing patients to remain

Summary of findings

registered where ever they moved to. The appointment system had been continually reviewed and provided flexible 15 minute appointments at times to suit patients. Telephone appointments were available throughout the day for working patients and extended hours every Tuesday evening. Additionally, the practice had early appointments set aside for working patients every Monday and Friday. There was an online service for booking appointments and requesting repeat prescriptions. The text messaging service was used to remind patients about follow up appointments and reviews linked to repeat prescribing.

Health checks for patients over 40 years of age were available and the practice was actively raising patient awareness of these. For example, the virtual PPG newsletter had been used for this purpose and was published on the practice website.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people, in particular students registered at the practice.

The practice had analysed the needs of the total population registered with them and identified a high percentage of patients were students at the local university and college. Patients lived in temporary rented accommodation, which could mean they moved to a totally different part of the city. The practice promoted continuity of care and had a policy allowing patients to remain registered where ever they moved to. The appointment system had been continually reviewed and provided flexible 15 minute appointments at times to suit patients. Telephone appointments were available throughout the day for working patients and extended hours every Tuesday evening. Additionally, the practice had early appointments set aside for working patients every Monday and Friday. There was an online service for booking appointments and requesting repeat prescriptions. The text messaging service was used to remind patients about follow up appointments and reviews linked to repeat prescribing.

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People whose circumstances may make them vulnerable

Outstanding

The practice identified that there was a high percentage of young families, some of whom lived in a deprived area registered with

them. Fundraising at the practice provided additional support to these families including a taxi fund, which was accessed for patients at times of need. During the year 32 patients out of the total of 3,633 had benefitted from this fund.

Patients with a learning disability had an annual health check every year, during which their long term care plans were discussed with them and their carer if appropriate.

Patients for whom English was not their first language were offered interpretation and translation services. Some staff had also attended ethnic minority awareness sessions to provide awareness of communication difficulties.

GPs had often referred vulnerable, housebound patients to the community matron and community nurses who visited them at home to assess their needs. Staff from the practice also visited patients at home when they had expressed reluctance to attend the practice for either emotional or health reasons.

The practice had a successful, active carers support group which provided a social, network and support for isolated and vulnerable patients. The co-ordinator had a team of volunteers who offered services including telephone support, a sitting and befriending service, social events and excursions and health promotion events. Patients at the practice also had an allotment club, which provided opportunities for vulnerable people to build networks within the community.

The practice did not provide primary care services for patients who were homeless. This was because there was a specific GP practice for homeless people in the area. However, staff said they would not turn away a patient if they needed primary care and could not access it.

The practice worked with community health care professionals including physiotherapists and a community pharmacist and matron to make sure they visited vulnerable patients in their homes to assess needs and facilitate provision of any equipment, mobility or medication

There were a small percentage of patients who were known sex workers. The nursing staff had undertaken additional courses to provide them with the skills and experience to undertake numerous screening programmes. The team were also skilled communicators and as a result had built a trusting rapport with these patients. Data showed that the practice was achieving higher levels of success in screening patients for sexually transmitted infections such as chlamydia screening when compared with the local and national statistics.

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People experiencing poor mental health (including people with dementia)

Outstanding

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

The practice had been at the forefront of developing support and services for people in Exeter through it's membership of the Mental Health Collaborative with Devon Partnership NHS Trust. The team had undertaken additional training, which extended their skills in assessment of patients with complex mental health needs. Longer appointments and home visits were available. Staff knew their patients well enough to detect early signs of relapse and worked closely with them and their family to keep them safe. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For example, 94% of patients had experienced a discussion about their lifestyle and needs. Cervical screening had taken place for 82% female patients with complex mental health needs.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice supports patients living in an adult social care home. Advance care planning was in place and 89% patients with dementia had been reviewed face to face in the previous 12 months.

GPs had audited treatments prescribed for all patients with dementia and had made changes in line with national guidance. The timing of reviews was planned according to individual need and not restricted to set parameters. Therefore, some patients were experiencing treatment reviews monthly, quarterly or more frequent as required.

Patients with alcohol and drug addictions benefitted from the extended skills of the GP partner and nurses, which meant they were able to manage suitable patients detoxification in the community. They did this in conjunction with a specialist agency, which provided additional on-going support to people in this situation.

Summary of findings

What people who use the service say

We looked at patient feedback from the national GP survey from 2014, which 250 patients took part in. High levels of satisfaction were seen in the survey responses. Access to the practice was very good and patients could see a GP quickly. 93% of patients were satisfied with the care and treatment they received. There was very positive feedback about the way staff spoke with and supported patients, for example 98% patients found the reception team helpful or very helpful. All of the feedback was positive.

We spoke with eight patients during the inspection and collected 24 completed comment cards which had been left in the reception area for patients to fill in before we visited. On 22 of the 24 of the comment cards the feedback was positive. Patients said their care was very good, they had been listened to, and they could access the practice easily. They told us that they found the reception staff to be helpful and caring. Two patients highlighted that the waiting time for routine appointments could be improved. In 2014 patients were asked their views about having an online appointment booking system as well as call waiting when phoning in for appointments. The practice developed an action plan and set up an online appointment system and made changes to the telephone system.

The practice had a virtual patient participation group (PPG) and fundraising charity consisting of more than 100 patients from a cross section of the practice population as confirmed by a study the practice shared with us. We spoke with the chair person of this group. The PPG felt that the relationship with the partners was good and they worked closely with them to fund raise and improve services and facilities at the practice. For example, a new chair had been purchased for a treatment room where patients had blood samples taken. There was a taxi fund, which provided transport for patients at times of need. The building was owned by the NHS and so the practice was limited in being able to make the access improvements they wished to make. The PPG and Friends of Foxhayes group had been fully involved in finding accessible and larger premises for the practice.

Outstanding practice

- The practice was caring and extremely patient centred. Eight patients we spoke with and 24 in comment cards confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. The mission statement was developed and reviewed with patients. New patients were welcomed personally with a letter and one to one introduction. During the year, 32 patients in vulnerable circumstances had been give support through the practice taxi fund.
- The practice understood the needs of the entire patient list and had developed a responsive service accordingly. For example, early morning appointments were available twice a week and extended opening available one evening per week. The text messaging service had been extended to improve outcomes for patients with long term conditions. The patient list was managed in a way to avoid any barriers.,
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice worked collaboratively with a larger GP practice situated close by to provide access to comprehensive midwifery services for young pregnant mothers. The practice had a successful, active carers support group which provided a social, network and support for isolated and vulnerable patients. The co-ordinator had a team of volunteers who offered services including telephone support, a sitting and befriending service, social events and excursions and health promotion events. Patients at the practice also had an allotment club, which provided opportunities for vulnerable people to build networks within the community.
- There was a high incidence of patients registered at the practice with substance misuse problems who wished to change their lifestyle. The GP partner had

completed additional training and was a qualified pharmacist so had the skills and experience to safely manage the detoxification process for suitable patients living in the community. He did this in conjunction with specialist agencies who provided further support for the patients. This facilitated continuity of care for patients in such situations.

Foxhayes Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a variety of specialists: a practice manager and an expert by experience.

Background to Foxhayes Practice

Foxhayes Practice provides primary medical services to people living in the city of Exeter and the surrounding villages.

At the time of our inspection there were 3,633 patients registered at the Foxhayes Practice. The practice is unusual in that it was established ten years ago by two full time partners; one GP (male) and the other an Advanced Nurse Practitioner (female) both hold managerial and financial responsibility for running the business. In addition there is a female salaried GP who works part time. The GPs were supported by two other female registered nurses, one of whom is also an advanced nurse practitioner, a female health care assistant and additional administrative and reception staff.

The practice supports four adult social care homes in the area.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

The practice held a primary and general medical services contract . Foxhayes is an approved training practice providing vocational placements for GPs and medical students. Foxhayes is a training practice, with a GP partner approved to provide vocational training for GPs, second year post qualification doctors and medical students.

Foxhayes Practice is open from 8am-6pm Monday and Friday. On Wednesday and Thursday the practice is open from 8.30am-6pm. Late evening pre booked appointments are available on a Tuesday until 8:15pm for patients that find it difficult to visit the GP during the day. With the except of Tuesdays, after 6pm every evening and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. The out of hours arrangements are in keeping with all GP practices across the North, East and West Devon clinical commissioning group.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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.

How we carried out this inspection

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 14 November 2014.

During our visit we spoke with the GP partner, nurse partner who is an advanced nurse practitioner and prescriber, another nurse practitioner, health care assistant and administrative and reception staff. We also spoke with five patients who used the practice. We observed how patients were being cared for and reviewed comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. All of the staff we spoke with knew how to raise concerns including reporting incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Patients told us they felt safe when attending the practice.

The GP partner told us that when they received MHRA alerts (medical alerts about medicines safety) they searched their patient records to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. The lead GP also shared medical alert information with other clinical staff in the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw the records of seven significant events that had occurred during 2014. Team meeting minutes showed significant events were discussed to identify concerns and share learning with the staff. This included temporary staff working at the practice such as medical students, GPs in training and locum GPs. The significant events log was discussed and trends highlighted where appropriate. The practice also reviewed annual performance by looking at the total number of face to face consultations that had taken place, all written feedback from patients, including complaints.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked two of the seven incidents recorded for 2014 and saw records were completed in a comprehensive and timely manner and showed action had been taken. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. For example, as a result of complaints from some patients about their repeat prescriptions not being received or ready at pharmacies the practice had introduced a tracking system. The practice used seven inner city pharmacies and was able to track when a repeat prescription had been issued at the practice and collected by the pharmacy to be made up for patient collection. The system showed that the practice issued repeat prescriptions in a timely and responsive way.

National patient safety alerts were disseminated electronically via the practice intranet to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that 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 also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible in every treatment room.

The nurse and GP partners were both leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example, they had completed level 3 children safeguarding training. All of the staff had completed basic (level 1) safeguarding training for adults and children. All of the nursing staff had also completed intermediate level 2 safeguarding training for adults and children. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system 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 and adults at risk. We looked at the

virtual ward record for September 2014. This showed the practice closely monitored patients and carers needs in conjunction with key health and social care professionals supporting them.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Patients could choose to be seen by either a female or male GP(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). All nursing staff, including health care assistants, had been trained to be a chaperone. The training was evidence based and had raised staff awareness about the recommendations from the Ayling Inquiry for example. Partners at the practice were mindful of the learning from this enquiry and the complaint system included regular audits, which was set up so that early identification of any concerning trends and themes would be identified.

Medicines Management

The GPs were responsible for prescribing medicines at the practice. Two nurses also held nurse practitioner qualifications and had done additional training to enable them to prescribe medicines. The control of repeat prescriptions was managed well. Prescription scripts were kept secure when not in use. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes and had direct access to their personal records on request. They were notified of health checks needed before medicines were issued. Patients explained they could use the prescription drop-off box at the practice, send an e-mail. The practice had set up an on-line request facility for repeat prescriptions.

Arrangements were in place for the safe management of medicines. The practice nurse was responsible for the management of medicines within the practice and there were up-to-date medicines management policies. Medicines were kept secure in a locked cupboard. The arrangements for storing the keys to this cupboard were slightly altered during the inspection to further increase security. Controlled drugs were stored in the locked cupboard and only authorised staff had access to these. Expiry date checks were undertaken regularly and recorded.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Training records showed that nurses had received appropriate training to administer vaccines. Fridge temperatures were checked daily showing that medicines were stored at the correct temperatures and were safe to give patients. For example, records showed that the practice had responded promptly when fluctuations in temperatures were seen thought to be caused by the failure of the fridge. Advice was sought from the Department of Health about the safety of medicines affected and a new vaccines fridge was purchased.

Patient participation group members told us they had helped the team with the flu vaccination campaign, directing patients into the venue and provided teas and coffees whilst they waited. Information about who was eligible for flu vaccination was clearly displayed in the waiting room and on the practice website.

Cleanliness & Infection Control

Eight patients we spoke with told us the practice was always clean and tidy and this was borne out by our observations. Twenty four patients in comment cards fed back that they had no concerns about cleanliness of the practice.

The practice had a lead nurse responsible for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received regular updates. Nursing staff said they had carried out a comprehensive audit of the practice 2014. They showed us this audit and the previous one from 2013. Practice meeting minutes showed the findings of the audits were discussed with staff and changes made as a result. For example, a protocol for cleaning privacy curtains and blinds every in treatment rooms was developed and being followed by the cleaning staff every six months.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, two nurses told us they cleaned equipment used to test patients blood pressure and lung capacity after every patient. Treatment rooms were cleaned at the beginning and end of every session. Paper covers were used on equipment and changed after every patient.

Policies in place covered areas such as personal protective equipment (PPE) including disposable gloves, aprons and

coverings were available for staff to use. The practice had taken an evidence based approach and did not require staff to wear uniforms. Research had shown that the wearing of uniforms could be seen as a potential barrier for patients increasing levels of anxiety. Staff demonstrated that they followed the practice's infection control policy and wore PPE when carrying out more invasive procedures such as taking blood or cervical screening. The practice had a needle stick injury policy, which linked with occupational support for staff in the event of an injury. Staff told us they had been made aware of the latest guidance about needles and were using safer equipment outlined in this document.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The policy for handing samples for investigation clearly set out how these should be handled to reduce the risk to staff. The policy was not being followed, for example when patients brought urine samples in for testing we saw staff handling these with tissues. No gloves or a receptacle for the specimens was available in reception. This was rectified immediately after we raised concerns about it.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice produced records showing that a risk assessment had been carried out by an external contractor. Action plans had been put in place following the assessment to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly for patient use and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. Calibration of medical equipment was undertaken by an external contractor annually and we saw the inspection report and certification for 2014.

Staffing & Recruitment

A patient participation group member told us that patient representatives sat on interview panels when new staff were recruited. We looked at four staff records, all of which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). One staff file did not contain photo identification, which the practice manager said they had reviewed for the DBS check but would obtain again from the individual and hold on record. The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only nurses or healthcare assistants had this additional duty and a DBS had been obtained for all of them.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. For example, two nurses said they were never expected to work outside of their scope of practice. They shared examples of how their professional competencies linked with health promotion clinics being delivered. For example, the nurse partner had completed several advanced nursing diplomas. These included the respiratory care of patients, diabetes management, contraception, sexual health promotion and mental health issues. Two out of three of the nurses working at the practice held qualifications allowing them to prescribe medicines. This included on-going assessment of their competency to prescribe treatment for patients. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records demonstrating that actual staffing levels and skill mix were in line with planned staffing requirements. Each day the GP on rota responded to urgent needs from patients. This included making home visits where necessary between patient sessions. Nursing staff had a broad range of responsibilities and tended to

see patients with more complex needs. Some of the nursing responsibilities were delegated to a healthcare assistant and included taking blood pressures and blood for testing. Training records and discussion with these staff verified that they had undertaken further training and assessed as competent before carrying these out. For example, a healthcare assistant confirmed they had completed a blood taking course at the hospital phlebotomy department. They said they felt well supported by the nurses and shadowed them until they felt confident and were assessed as competent to take blood from patients for testing.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included daily, weekly, monthly and annual checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, all of the reception team had been trained to recognise potential emergencies. A high percentage of patients using the practice experienced episodes of mental health crisis. The team were very skilled at observing the emotional and psychological well being of patients and were able to recognise if a patient was in distress. The team worked closely with the community mental health team to ensure patients in crisis received appropriate support quickly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and had an annual update in 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were regularly checked.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The lead practice nurse carried out regular audits of this equipment to ensure that procedures for maintaining the equipment were being followed. This provided the practice with an additional layer of assurance that emergency equipment was fit for purpose.

A business continuity plan was in place 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, adverse weather, unplanned sickness and access to the building.

Fire safety policies and procedures were in place. Information about checks and guidance for staff was in one place and held in reception. A fire risk assessment had been undertaken. Records showed staff were up to date with fire training and regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Care pathways were used by staff to clearly outline the rationale for their approaches to treatment. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GP and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The practice was taking part in a pilot study run by the local university to assess and predict risks for vulnerable patients, which also involved assessment of patients social support networks.

The GP partner told us there was a joint leadership approach with the advanced nurse practitioners for management of diabetes, heart disease and asthma for patients. This allowed the practice to focus on specific conditions aligned with the patient population needs. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The partner GP told us this supported all staff to continually review and discuss new best practice guidelines. For example, diabetes outreach clinics were run for patients and risks for vulnerable patients were reviewed in conjunction with the diabetic consultant. Virtual ward meeting minutes confirmed that this happened.

The nurse partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with dementia. This showed some treatments were reviewed and timings for future reviews were planned and person centred. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within a week by their GP according to need.

National data showed that the practice was in line or better regarding referral rates to secondary and other community care services for all conditions. The GP partner we spoke with confirmed that the practice used national standards for the referral. For example, patients with suspected cancers had been referred and seen within two weeks. Staff showed us systems in place to closely monitor referrals made and follow up with secondary services if no outcome letter was received.

Discrimination was avoided when making care and treatment decisions. Interviews with all the staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. All of the staff understood the diversity of the patient group registered at the practice, which had a higher percentage of young adults at university and deprived families. Training delivered to the team had particularly focussed on sexual and mental health issues to meet the needs of patients using the practice.

Management, monitoring and improving outcomes for people

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 the nurse partner to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. We saw two cycles of audit had been completed with improved outcomes for patients in three areas: Recorded consent was much better for the second cycle at 100% versus the first cycle at 84%; samples sent for testing in the second cycle was 95% versus 84% at the first cycle; and correlation of diagnosis in the second cycle was 95% versus 62% in the first.

Are services effective?

(for example, treatment is effective)

The GP and nurse partners 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, we saw an audit regarding the prescribing of analgesics. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. Data from the clinical commissioning group showed that the practice was better at monitoring antibiotic prescribing when compared with other GP practices nationally.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 85% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff demonstrated they knew the key areas of need amongst the patient group registered at the practice. For example, a high percentage of patients presented with complex mental health needs including addictions. The staff closely monitored the health and well being of patients and used nationally recognised tools to assess addictive behaviour, signpost or refer patients on to specialist services.

A protocol for repeat prescribing which was in line with national guidance was in place. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Eight patients we spoke with confirmed this took place. Routine health checks were monitored and completed for 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 looked at an audit which looked at treatments prescribed for patients with a diagnosis of dementia. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. The timings of reviews were planned to be totally patient centred.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Each month patients were discussed and records showed that the practice used a traffic light system to highlight levels of risk. There was a clearly co-ordinated plan for each patient on the risk register, which was reviewed each time.

Effective staffing

Foxhayes provided training placements for GPs and medical students. The GP partner was an approved trainer and works in conjunction with the local medical deanery. Vocational training placements at the practice had been subject to regular scrutiny by the medical deanery.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with the GP partner being dual qualified as a doctor and pharmacist. The two GPs at the practice also held additional diplomas in sexual and reproductive medicine. GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a health care assistant had attended a phlebotomy course. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Are services effective?

(for example, treatment is effective)

Foxhayes Practice was set up as a nurse led practice when it opened in 2004. One of the partners was an advanced nurse practitioner holding diplomas in asthma and chronic obstructive airways disease management. The nurse partner and a practice nurse were qualified prescribers which meant that they could diagnose and prescribe some types of medicines for patients. Training records, audit and policies showed this was done safely. For example, the extended nursing role and on-going training meant that the nurses had been assessed as being competent to see patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease and help them manage their health care. A multidisciplinary approach was taken regarding patients with complex needs, which involved joint discussions with the GP partner, other GPs and specialists.

The practice had policies and procedures in place to manage poor performance if necessary.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both 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 communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required and did this every day. 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 appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw that the policy for action of hospital communications was working well in this respect. Data showed the practice had low rates of unplanned admissions for patients.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate 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. Electronic systems were also in place for making referrals through the Devon single point of access scheme. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic summary care record and planned to have this fully operational by 2015. Summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

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.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, the practice supported patients living in an adult social care home and the lead GP had met with patients and their advocates to develop a treatment escalation plan for each person. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care

plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. For example, staff said that they always explained procedures to patients and sought their and/or parental consent before starting it. They demonstrated that they monitored patient behaviour throughout and would stop if the patient showed discomfort but was not verbalising it.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in 100% of cases.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint. Some patients registered at the practice lived at three adult social care homes and the team at Foxhayes also understood the procedures for reporting suspected unlawful restraint to the local safeguarding board.

Health promotion and prevention

The practice had strong links with the clinical commissioning group through the membership of the nurse partner on the board. The Joint Strategic Needs Assessment (JSNA) pulls together information about the health and social care needs of the local area. The practice had used this information to help focus health promotion activity. The practice knew that there was a small number of sex workers registered at the practice as well as a high student population linked with the university. Health promotion activity had focussed for example on the early diagnosis and treatment of chlamydia and cervical screening. Data showed that the practice had achieved a 79% uptake of cervical screening which is much higher than the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture at the practice for all clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The team identified that there was a high proportion of patients potentially at risk of alcohol abuse due to high deprivation levels. For example, opportunistic alcohol screening and advice was being given to patients. The practice worked closely with third sector providers specialising in drug and alcohol addiction support and was referring patients who wished to detox and change their lifestyle to it for support.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed there was a good uptake of patients in this age group who had had health checks. A GP explained that patients were followed up immediately if they had risk factors for disease identified at the health check and scheduled further investigations. For example, a patient with symptoms indicating that they had chronic renal failure was promptly seen and had begun treatment.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all had been offered an annual physical health check.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was consistently above the CCG average for all childhood immunisations. In the at risk group, the practice had immunised 100% of children aged between 6 months to under 2 years. For patients aged 65 years and over, the practice flu vaccination performance was 78.7% compared with the average CCG level of 72.2%. Staff described how this also linked to patient records, which showed when children and siblings within the same family were at risk of suspected or actual abuse. The practice had a clear policy for following up non-attenders by a named practice nurse.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The most recent data available for the practice on patient satisfaction showed very high levels of satisfaction. This included information from the national patient survey 2014: 250 patients participated and 96% patients described the overall experience of their GP surgery as fairly good or very good. For a practice of this size this is a high level of response. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was also had above average scores for its satisfaction scores on consultations with doctors and nurses with 93% of practice respondents saying the GP was good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and 22 were positive about the service experienced. Patients said they felt the practice offered an excellent service and put their needs first. Staff were described as being efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients commented that when they registered with the practice, they experienced a personal approach in which staff introduced themselves by first name and welcomed them to the practice. All of the patients and staff were on first name terms and this was enshrined in the mission statement, which had been developed with patients.

The practice had clear policies and procedures in place around confidentiality, which were being followed Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. The waiting room was compact and patients said that the staff did their best to be discreet with them in a confined space. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the partners. The practice manager/nurse partner told us she would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Reception staff demonstrated they understood how to diffuse potentially difficult situations and confirmed they had received training on this. Equally, we saw staff put patients at ease which had a positive effect on engagement with patients that had complex mental health needs.

Another GP nearby practice in Exeter specialises in supporting people whose circumstances may make them vulnerable, for example homelessness and/or complex mental health needs. However, staff at Foxhayes said they would always offer help to register a patient at the practice in these circumstances. Training records for 2013 showed that the team had been equipped to recognise and treat people in a sensitive way to stamp out discrimination and improve access to health care. Records showed the practice had plans in place to provide an update for staff in 2016.

The practice was compassionate about helping patients in deprived circumstances. The practice had a taxi fund to assist patients at times of need. During the year, 32 patients had received help from this fund. Staff shared two examples with us and these included a mother and child who was unwell daughter being offered money for a taxi during a rain storm to avoid them having to get home by bus. Another example was the taxi fare being paid for an elderly patient so they could get to the surgery.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 88% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these

Are services caring?

results were above the national averages of 81% and 85%. The results from the practice's own satisfaction survey showed that 97% of patients said they were sufficiently involved in making decisions about their care.

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.

Patient/carer support to cope emotionally with care and treatment

In a practice survey of 250 patients carried out in 2014, patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93% of patients considered they were treated with care and concerned during their consultation with the clinical team. The eight patients we spoke with on the day of our inspection and 24 comment cards we received were also consistent with this survey information. For example, comments highlighted that all of the staff were compassionate, caring and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also 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. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Foxhayes Practice had achieved a local carers award for the support provided to carers in 2006. The practice had links with a carer support worker and ran a carers group, which provided access to advice and information.

The practice worked closely with the community of Exwick. Patients at the practice had set up an allotment club, which provided network opportunities in the community to help reduce the risk of isolation. Patients were signposted to other activities in the community singing groups, well-being services and lunch clubs. Patients had benefitted from this in many ways. For example, staff reported that patients who had attended healthy living centres had reduced weight, made new friends ,thus reducing their social isolation. A patient who had joined a singing group had made new friends and had lifted their mood and self-esteem, and the number of appointments with the nurse practitioner had reduced.

Staff at the practice were skilled in assessing patients mental well being. They promoted talking therapies and signposted patients to counselling services such as the depression and anxiety service. Flexible appointments were available for patients coming to terms with bereavement and anxiety and depression. The practice had a history of working collaboratively with the local mental health trust to improve services for people. The practice recognised that access to psychological therapies was limited, so had looked at ways to meet this for patients. Senior staff had undertaken additional mental health training, which provided them with assessment and counselling skills.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, there was a high incidence of patients registered at the practice with substance misuse problems who wished to change their lifestyle. The GP partner had completed additional training and was a qualified pharmacist so had the skills and experience to safely manage the detoxification process for suitable patients living in the community. He did this in conjunction with specialist agencies who provided further support for the patients. This facilitated continuity of care for patients in such situations.

The NHS England Area Team and North East and West Devon Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The nurse partner represents the people of Exeter locality at the CCG and had raised awareness of key priorities and developments for patients at the practice. The practice website had information for patients about service improvements and how this linked with the whole area plans for transformation of health and social care.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the virtual patient participation group (PPG). For example, an annual report that looked at results from the 2014 patient survey and reviewed progress to date outlined that the partners were committed to implementing an online appointment service for patients. Additionally, text messaging was highlighted as a method of communication to enhance the way in which the staff team communicated with patients. Following consultation with members of the Friends of Foxhayes and virtual PPG about the finer details of the service, the online appointment service had been set up.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, a large proportion of patients registered were students attending the local university living in rented accommodation. Staff told us that the practice policy enabled patients to stay registered for continuity of care even if they moved to another part of Exeter. Information held by the practice meant that the team had a good overview of patients living in vulnerable circumstances. The practice was taking part in a pilot to test an assessment system which flagged vulnerability in individual records and included social networks. There were no barriers to registering with the practice, including those with "no fixed abode". The practice worked closely with a neighbouring practice which specialised in primary medical services for people who were vulnerable due to their housing situation and had complex mental health needs including drug and/or alcohol addiction.

Records showed that 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. The practice had access to online and telephone translation services. Staff understood how to access this service, but told us this was rarely used as patients whose first language was not English tended to bring a family member or friend with them to provide translation.

The premises and services had been adapted to meet the needs of patient with disabilities. However, there were known limitations with the building which the practice could not overcome. The nurse partner explained that the premises were rented from the NHS and this along with the building constraints meant that further adaptations would be difficult to achieve. A PPG member told us that the practice was working closely with patients and was looking for alternative accessible premises which could be adapted. The waiting area was somewhat limited to accommodate patients with wheelchairs and prams. Treatment and consultation rooms were all situated on the ground floor and could be accessed easily. Accessible toilet facilities were available for patients attending the practice and included baby changing facilities.

Access to the service

The majority of patients in 24 comment cards and those we spoke with were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their

choice. Comments received from patients showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice. For example, we saw the reception staff offering an appointment to a patient over the telephone and then met the person within half an hour of their phone call when they arrived to be seen. The national average for appointment availability is 70 per 1000 registered patients. Foxhayes was exceeding the practice requirement for appointments. For example, over a period of 10 days between 10 – 21 November, 669 appointments were provided.

Parents of children told us appointments were available outside of school hours to minimise disruption to the school day.

Over the last 12 months the practice had utilized text messaging as a means of communicating to patient's confirmation of their appointments; date and times. This was particularly responsive for students, young patients and families registered at the practice. Reminders were being sent to patients signed up to the service 24 hours before their appointment. Staff told us that feedback from this had been positive and favourable. This was also borne out in the discussions we had with eight patients.

The team built on the success of the appointment text service and had explored other ways in which messaging could be utilized to improve the communication with registered patients. A new service for patients who were on long term medication had been set up. The team decided to focus this initially on patients who have hypothyroid disease. Once patients consent was obtained, a text message was transmitted to patients to remind them to arrange an appointment for a blood test. Patients had been given the choice of a text message or a telephone call as to how they wanted to receive their results of the blood test. A similar service had been offered to patients with hypertension and was in the early stages of development.

The practice offered flexible, 15 minute or longer appointments for patients if needed. Staff demonstrated sensitivity towards patient mental health needs and booked appointments at quieter times of the day. The practice had an online appointment booking system and appointments were available before the main surgery times twice a week. Telephone appointments were available and the practice remained open to patients over the lunchtime period between appointment sessions. The practice also had extended opening every Tuesday evening until 8pm to avoid disruption for working patients. A PPG member told us discussions were underway about offering appointments at the weekend. Negotiations were underway to run evening clinics for patients with complex long term health conditions so their health could be monitored. Patients with type one diabetes requiring treatment with insulin would be targeted for this new planned service.

Other online services such as ordering repeat prescriptions were available to patients on the practice website.

Home visits were made to a local nursing home on a specific day each week, by a named GP and to those patients who needed one. We looked at the overall figures for the number of patient appointments provided in November 2014, again these exceed what was expected of this small practice.

The practice worked collaboratively with a larger GP practice situated very close to Foxhayes to provide access to comprehensive midwifery services for young pregnant mothers.

Listening and learning from concerns & complaints

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

Information was available to help patients understand the complaints system. Posters were displayed and leaflets summarising the system were given to new patients. Eight 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.

We looked at an audit the practice had completed which looked at complaints received in the last 12 months. This showed complaints were satisfactorily handled and dealt with in a timely way. The practice was open and transparent in dealing with complaints and viewed this in a positive way to improve the service. The review of complaints helped the practice to detect themes or trends. However, no themes had been identified. Lessons learned from individual complaints had been acted on.

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 deliver high quality care and promote good outcomes for patients. A representative from the virtual patient participation group explained that the mission statement for the practice had been developed with patients. The vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in a leaflet given to new patients. The practice vision and values welcomed and treated patients with dignity & respect, ensured they were listened to and believed and their needs addressed. Patients were also encouraged to be responsible for their own health by feeling part of the healthcare decisions, which effected them and their family. The mission statement also highlighted that patients should feel part of the health community and able to contribute to developments.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. There was a scheme of delegation of responsibilities for policies and procedures, with oversight from the two partners at the practice. All of the policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line or better than expected with national standards. The practice performance was at 98.1% at end of March 2014 and in the top five practices of the North, East and West Devon Clinical Commissioning Group. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. For example, prescribing of medicines was closely monitored to ensure decisions about prescribing were evidence based and value for money.

The nurse partner was a member of the clinical commissioning group and on the editorial board of the Practice Nurse journal. Foxhayes practice had close links with the universities as a teaching practice.

Clinical audits were undertaken which it used to monitor quality and systems to identify where action should be taken. We noted that these were completed two cycle audits. For example, inadequate cervical cytology results were reviewed annually across the whole team highlighting areas for improvement. In addition to this, methods for engaging with female patients had been reviewed and changes made to improve the update of cervical screening. The practice had a much higher uptake of 78% female patients having cervical screening when compared to national and local data (60% and 68%).

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. For example, an incident involving one of the refrigerators was recorded on the risk register. Daily checks to ensure the integrity of vaccines had shown one fridge to have fluctuations in temperature over a weekend. Emails and receipts showed that new equipment had been purchased and advice sought from the Department of health about the integrity of the vaccines. The risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, the emergency bag used in the event of fire contained the fire log, risk assessments and checklists for staff. Staff said that having all this information in one place was reassuring in the event of an emergency.

The practice did not have a formal structure for governance and business meetings between partners, which we highlighted when giving feedback as an area that could be improved.

Whilst we saw clear evidence that the practice was well led we noted that there did not appear to be formal meetings between the partners. We consider that this would be

Are services well-led?

Good

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

beneficial for their mutual support and the sustainability of the innovative structure that the practice demonstrated. We highlighted this when giving feedback as an area that could further strengthen the practice.

Leadership, openness and transparency

We reviewed minutes of team meetings prior to the inspection. These showed meetings were held regularly, at least monthly and included trainee and student doctors. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Team away days were held for half a day every six to nine months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example recruitment and induction policy which were in place to support staff. We were shown the electronic staff handbook, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and 67% of patients felt that on line appointment booking would be useful. We saw as a result of this the practice had introduced on line booking for appointments and repeat prescriptions.

The practice had an active virtual patient participation group (PPG) which had a membership of approximately 100 patients as well as a 'friends' of the practice group for fundraising. The virtual PPG included representatives from various population groups; patients with long term and mental health conditions, older and disabled people, mothers and young people. The virtual PPG sent members information at least five times per year to consult with them about proposed developments at the practice. The practice manager showed us the analysis of the last patient survey. The results and actions agreed from these surveys were available on the practice website.

There was a low turnover of staff at the practice, however the practice recruitment procedure stated that when new staff were recruited patients were involved in shortlisting and on the interview panel. For example, a healthcare assistant recruited in 2014 told us a patient representative had been part of the interview panel when they were employed earlier in the year.

The practice had gathered feedback from staff through staff away days, 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. One member of staff told us that they had asked for extended training during the induction period and felt supported throughout. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Foxhayes had a strong culture of reflective learning. All of the staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. For example a practice nurse had completed an immunisation update and had other training booked linked to their development plan.

The practice was a GP training practice so provided placements for pre qualification medical students and GPs in training. However, at the time of the inspection there were no students or GPs in training at the practice. The GP partner had been qualified as a trainer for two years and each week had two sessions set aside for their own development in this role. These sessions were covered by a salaried GP.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, the process for handling swabs and other samples before the weekend had been reviewed so that these were received at the hospital on the same day.