The South Lawn Medical Practice

Quality Report

The South Lawn Medical Practice
Heavitree Health Centre
South Lawn Terrace
Heavitree
Exeter
EX1 2RX
Tel: 01392 281101
Website: www.slmp.co.uk

Date of inspection visit: 29 July 2015
Date of publication: 29/10/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The South Lawn Medical Practice on Wednesday 29 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for services for older people, those with long term conditions, families and young people, the working age and recently retired and to patients with mental illness including those living with dementia. We found the practice was giving an outstanding service to patients whose circumstances may make them vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed and medicines were managed well.
- Staff were employed after robust recruitment checks had been performed and received training appropriate to their roles and any further training needs had been identified and planned.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw an area of outstanding practice which related to providing services to patient whose circumstances make them vulnerable:

- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patient need. The practice included a representative from the Friends of Heavitree Health Centre charity in unplanned admission meetings to offer social support, provide transport services and befriend housebound and isolated patients. Practice staff had worked with a learning disabilities charity champion to improve facilities and services at the practice. Involvement of the charity had resulted in the introduction of many 'easy read' guides on subjects including contraception, cervical screening, healthy lifestyle and smoking cessation. A GP had also introduced a you tube video of 'what to expect when you visit' to help anxious patients prepare for a visit to the surgery.

However there were areas of practice where the provider should make improvements:

- Ensure that regular audits of infection control arrangements are carried out.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, 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, however some minor improvements were suggested to improve infection control processes at the practice. Medicines were managed well and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

There was a culture of learning and development and staff had received training appropriate to their roles. Systems were in place to identify and plan for future training and development. There was a sense of team work and evidence of support, appraisals and personal development plans for all staff.

Staff worked with multi-disciplinary teams, external agencies and other health care professionals.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice equal to, or higher, than others for several aspects of care. Patients were pleased with the service they received and told us they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.

Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of the local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. There were good facilities and was well equipped to treat patients and meet their needs.

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

Are services well-led?

Good

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

The practice had a clear vision and strategy. Staff had been involved in writing the practice mission statement and were clear about their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the GPs and by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient participation group (PPG) was active.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of Older people

Older patients at The South Lawn Medical Practice had an allocated GP as the partners had personal lists. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people. The practice nurses visited housebound patients not on the community nurse caseload to administer the seasonal influenza vaccinations.

The community nursing team was based within the health centre which helped communication and access to the service.

The practice had a system to identify older patients and coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. The practice held regular quarterly meetings with Hospiscare nurses and community nurses to facilitate this.

The practice worked with the community matron who facilitated care for older patients with complex needs.

The Friends of Heavitree Health Centre offered various services for the practice patients, including a memory café, transport service, befriending service, shopping service and lunch club. This reduced social isolation for older patients.

The practice had systems in place to avoid unnecessary admissions to hospital. Practice staff worked with other health care professionals to provide joint working. Any patient deemed at high risk of admission was given access to the direct telephone number for the practice to avoid them having to ring through the automated switchboard service. Same day appointments were available for these patients when appropriate.

The practice was all one level for easy access. Chairs in the waiting room had been changed to include some with risers to assist patients to stand.

People with long term conditions

Good

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

The practice had systems to identify patients who might be vulnerable, have multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. All patients with long term conditions were offered annual

Summary of findings

reviews. Extra appointments were available each day to allow for patients to have blood tests and other investigations as required by the GP, without the need for them to make another appointment and re-visit the surgery.

The staff at the practice worked with external health care professionals for advice and guidance. Patients could make an appointment at a time suitable to them to have long term conditions monitored. These included monitoring of diabetes, heart failure, hypertension, high cholesterol, renal failure, asthma and chronic respiratory conditions.

A system was in place to ensure staff received regular National Institute for Health and Care Excellence (NICE) guidance updates to ensure that clinicians were managing conditions in the most current evidence based way. Nurses received regular tutorials and educational updates to ensure their knowledge and skills were up to date.

Practice staff offered diabetic appointments which included education for patients to learn how to manage their diabetes through the use of insulin. This included information on healthy diet and life style.

"Virtual Ward" meetings were also held annually with hospital consultants from the Royal Devon and Exeter hospital. This was an opportunity for the GPs to discuss more complex patients. Patients receiving certain medicines accessed medicine reviews at the practice to make sure the medicines they received were effective. Systems were in place to ensure that any patient given a new cancer diagnosis was reviewed at the quarterly team meetings to increase team awareness and improve continuity of care.

The practice computerised patient record system could be accessed by Out Of Hours service providers following patient consent. This improved continuity of care for patients.

Families, children and young people

Good

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

The practice offered baby and child immunisation programmes so that babies and children could access a full range of vaccinations and health screening.

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held weekly clinics at the practice and had access to the practice computer system and could speak with a

Summary of findings

GP should the need arise. The practice had effective relationships with health visitors and the school nursing team. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

Patients had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening for women. There were quiet private areas in the practice for mothers to use when breastfeeding.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse. Vulnerable patients were reviewed every quarter at the practice quarterly meeting.

Working age people (including those recently retired and students)

Good 

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

Patients could book appointments online and the practice had recently started promoting a phone 'app' for patients to make appointments or order prescriptions with ease using their mobile phone. The practice used a text message reminder service for patients that had signed up to the service.

There was a virtual patient participation group at the practice which had a high number of working age members. These patients used electronic communication to provide feedback to the practice.

Suitable travel advice was available from the GPs and nursing staff within the practice.

The staff took the opportunity to offer health checks to patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medicines reviews. The practice also offered age appropriate screening tests including prostate and cholesterol testing and were actively promoting NHS Health Checks.

Patients who received repeat medicines were able to collect their prescription at a place of their choice and a high proportion of prescriptions were processed electronically, giving patients a greater choice of pharmacy.

People whose circumstances may make them vulnerable

Outstanding 

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

The practice had a vulnerable patient register. These patients were reviewed quarterly and discussed at the quarterly practice meetings.

Summary of findings

For patients whose first language was not English staff had access to the practice interpretation service. The practice leaflet had been translated into five of the main languages encountered at the practice, including Polish and Bengali.

Practice staff were able to refer patients with alcohol addictions to an alcohol service for support and treatment. The support service visited the practice if the patient chose this.

The practice worked with a community matron who visited any vulnerable patients to assess and facilitate any equipment, mobility or medicines needs they may have.

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. Practice staff had access to a learning disability awareness training module through their online training software. There were many 'easy read' guides on subjects including contraception, cervical screening, healthy lifestyle and smoking cessation. Specific video links on the practice website showed more vulnerable patients what to expect when they attended the practice. For example, a GP had also introduced a DVD of 'what to expect when you visit' to help anxious patients prepare for a visit to the surgery.

Two GP partners took a lead role in supporting patients who experienced difficulties with substance misuse. By keeping the prescribing within the practice GPs maintained contact with the patients and therefore could also provide health education and prevention. The GPs also had an in-depth knowledge of not only their needs but those of their partners and families. The service also enabled the practice to foster links with the recovery and integration service (RISE) which provided support and a learning relationship for practice staff. Feedback from external support agencies had been positive.

The practice supported the Friends of Heavitree Health Centre charity which was based within the practice. The group provided transport services but also befriended housebound and isolated patients and offered a 'sitting service' to patients who were carers. The group offered Tai Chi classes, shopping trips and social activities which had reduced social isolation of vulnerable patients. The practice staff had raised money for this service and regularly gave items to use as raffle prizes. The practice encouraged any donations and grants to be used for patient use.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

A register at the practice identified patients who had a mental illness or mental health problems. Patients had access to an in house counsellor and were monitored when they had a diagnosis of depression.

The clinical software flagged up when a patient was at risk of dementia and appropriate screening was offered by the GP. Patients living with dementia had care plans which were reviewed regularly. In house mental health reviews were conducted to ensure patients received appropriate doses of medicines and had their physical health assessed. Blood tests were performed on patients receiving certain mental health medicines.

There was communication, referral and liaison with the psychiatry specialist. Staff appreciated the advice and support provided as a way of providing current practice and keeping their knowledge up to date.

Staff were aware of the Mental Capacity Act. The practice had introduced an online training programme and staff had started to access this.

Patients with mental illness and those living with dementia were discussed and reviewed during safeguarding meetings where appropriate.

Summary of findings

What people who use the service say

As part of our inspection process, we asked patients to complete comment cards prior to our inspection. We received 21comment cards and spoke with two members of the patient participation group (PPG). We also received two emails from other members of the PPG. Comments were detailed and all contained very positive comments and indicated that patients found the staff helpful, caring and polite and the majority described their care as very good. Patients praised the staff and said the facilities were clean and tidy.

Our findings were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results of the practice for 2013/14 showed that

- 93% of patients described their experience of making an appointment as good. This was higher than the local CCG average 83% and higher than the national average of 73%.
- 92% of patients found it easy to get through to this surgery by phone which was also higher than the local and national averages.
- 90% of patients stated that the last time they saw or spoke to a nurse or GP they were given enough time. This was similar to the local CCG average and was higher than the national average of 87%.

Areas for improvement

Action the service SHOULD take to improve

Ensure that regular audits of infection control arrangements are carried out

Outstanding practice

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patient need. The practice included a representative from the Friends of The South Lawn Medical Practice charity in unplanned admission meetings to offer social support, provide transport services and befriend housebound and isolated patients.

Practice staff had worked with a learning disabilities charity champion to improve facilities and services at the practice. Involvement of the charity had resulted in the introduction of many 'easy read' guides on subjects including contraception, cervical screening, healthy lifestyle and smoking cessation. A GP had also introduced a DVD of 'what to expect when you visit' to help anxious patients prepare for a visit to the surgery.

The South Lawn Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The South Lawn Medical Practice

The South Lawn Medical practice is situated in the residential area of Heavitree within the city of Exeter and has a mixed demographic. The practice shares the Heavitree Health Centre building with another GP practice which also has an independent pharmacy attached. At the time of our inspection there were 7,400 patients on the practice list. The majority of patients were of white British background. The practice demographics were similar to other practices nationally.

The practice has three male and two female GP partners, one salaried GP and two GP registrars. In addition there are four practice nurses, a healthcare assistant, a practice manager, a deputy practice manager and additional reception and administration staff.

The practice is a training, teaching and a research practice. The practice assists in the training of new GPs and the teaching of medical students, together with conducting research.

The practice is open 8.30am to 6pm Monday to Friday. There was a local agreement for patients requiring a GP outside of normal working hours. The are advised to contact the external Out Of Hours service that is provided by local GPs. The number of this service is clearly displayed in the reception area and on the practice telephone answering machine. The practice has a PMS (personal medical services) contract and also offers enhanced services for example; various immunisation and learning disabilities health check schemes.

The practice has a Personal Medical Service (PMS) contract and also offers Directed Enhanced Services, for example providing a service to patients with a learning disability.

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

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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 living with dementia)

Before visiting the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 29 July 2015. We spoke with members of staff, 15 patients and two members of the patient participation group (PPG) on the day of our inspection. We reviewed 21 comment cards and received two emails from members of the PPG.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. The staff we spoke with were aware of these systems and their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff were aware of where to find the incident forms and knew how to report these to the GP and practice manager.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of significant events that had occurred during the last two years were seen. We looked at four of these records which showed the system was followed appropriately. Significant events were discussed informally at the daily clinical meeting where immediate actions were discussed and reviewed then more formally at the quarterly staff meetings. There was evidence that the practice had learned from these and that the findings were shared with all staff. For example, a significant event involving issuing contraception to under 16 year olds had resulted in a change of practice policy and further education for all staff. We saw evidence that this significant event action and the policy had been reviewed.

Events were discussed and used to identify where learning could be identified but also where things had gone well. For example, a successful resuscitation of a patient had identified minor changes in where some equipment was located on the trolley but had also identified that staff were familiar with the training they had received.

Where patients had been affected by events or where something had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with told us alerts were discussed at management and staff 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. 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 within clinical areas and on the practice computer system.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary level three competency and training to enable them to fulfil these roles. 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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. The practice staff met with health visitors quarterly to discuss vulnerable patients.

There was a chaperone policy, which patients were aware of. (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, and some reception staff, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available but staff said this had not arisen for a number of years. Receptionists had also undertaken training and understood their responsibilities. All staff

undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Staff produced a policy explaining how medicines were kept at the required temperatures and were able to describe the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out daily which ensured medicines were stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw data which showed the practice compared well with other Devon practices for prescribing levels. The practice used a formulary to suggest alternative medicines for high risk medicines or costly medicines. Any outlying prescribing trends were discussed at the management and partnership meetings.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifyingmedicines, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injuries and staff knew the procedure to follow in the event of an injury.

The practice had a lead 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 annual updates. The last infection control audit had been performed in September 2013 and showed that the majority of actions had been completed on time or raised as part of future development. For example, the audit had identified that chairs within clinical areas were not easy to clean. The GPs explained this was part of the business plan over the coming 18 months. We noted that the practice used fabric curtains in treatment rooms. Staff explained they were laundered frequently but there was no evidence to show when the curtains had last been laundered.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The last date for this check had been July 2015.

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was June 2015. We saw evidence of the calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment of practice staff and locum staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We saw rota systems in place for all the different staffing groups to ensure that enough staff were 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. The GPs met daily to discuss workload and share home visits to ensure fair distribution of workload.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice shared the building with another GP practice who had overall responsibility for the maintenance of the property and services. The South Lawn Medical Practice had systems, processes and policies in place to gain assurances that risks were managed and monitored. These included regular checks of the building, boiler checks, fire safety checks and maintenance of some emergency 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 and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately. For example the recent cardiac arrest had identified the need to store two sets of pads which were now in place.

Emergency medicines were easily accessible to staff 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 whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Staff had various ways of alerting colleagues to an emergency including panic alarms, use of computer keyboard and button on the telephone. Staff explained a recent emergency demonstrated that these systems worked well.

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

Good

Are services safe?

sickness and access to the building. The document also contained relevant contact details for staff to refer to. This included a list of staff contact details and a chain of contact that key staff kept with them at all times. The plan was last reviewed in October 2014.

The practice had carried out a fire risk assessment in 2014 which highlighted no actions apart from continued maintenance of equipment. Records showed that staff were up to date with fire training and that they knew what to do in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. Any changes to NICE guidance were disseminated to staff during the clinical meetings which identified and agreed any actions to be taken. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with long term conditions were invited to a 'one stop shop' where multiple long term conditions could be reviewed and investigations performed in one appointment. Patients told us they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss current guidelines. The GPs regularly held tutorials for practice staff on specific conditions.

The GPs and practice nurses held a quarterly virtual ward with consultants and specialist diabetic nurses where patients with complex diabetic needs were discussed.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. The practice held monthly 'Avoiding Unplanned Admission' meetings with members of the multidisciplinary team. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs 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.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last three years. All of these were completed audits where the practice were able to demonstrate reassurances that standards were being maintained. For example, an audit in May 2014 looked to see whether female patients were receiving the recommended medicine combination of hormonal replacement therapy. The first audit showed the standard had been met. A repeat of the same audit five months later also showed the practice continued to be meeting the standard.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance (NICE).

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative

Good

Are services effective?

(for example, treatment is effective)

measures.) However, we also saw examples where the practice performed an audit in response to a NICE guideline. For example, we saw an audit to check prescribing guidelines were being followed for medicines used in the treatment and prevention of breast cancer.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, it achieved 434.70 of the 435 total QOF target in 2014, which was above the national average. The last full years report showed the practice had achieved maximum points for cancer reviews, depression assessments, review of patients with learning disabilities and referral of patients who had a stroke.

Specific examples to demonstrate effectiveness of the practice included data which included:

- A 78.4% score for administration of flu vaccinations for the over 65's. This was higher than the local average of 72.3% and the national average of 72.9%
- A score of 84.5% for cervical screening which was higher than the national score of 77.09%
- A score of 77.9% for asthma diagnosis compared with the national score of 64.79% and
- A score of 81% for coronary heart disease diagnosis compared with the national score of 70.94%.

The practice was aware of all the areas where performance was not in line with national or clinical commissioning group figures and we saw action plans setting out how these were being addressed. For example, A&E attendance was 88.9% which was higher than the national average of 79.44%. The GPs explained this was due to the close location of the emergency department in the area and had introduced a minor illness clinic led by the practice nurses to reduce A&E attendance.

The practice had a prescribing lead who monitored prescribing rates at the practice. We saw that these rates were similar or better than national averages. For example, the antibiotic prescribing rate was 0.23% compared to the national average of 0.28%.

There was a protocol and local formulary used for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had made use of 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. These meetings were held quarterly. Any specific information or details from a care plan were shared with the Out Of Hours provider following patient consent.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff, including locum staff had received a clear induction and support when starting at the practice. Staff were issued with a staff handbook which contained details of whistleblowing, equal opportunities, staff training, sickness and conduct issues. Staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which personal development plans were documented. The GPs also had an internal appraisal which included feedback from members of the team. Staff told us that the practice was proactive in providing training and funding for relevant courses, for example updates on immunisations and asthma care. 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.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, we saw formal external

Good

Are services effective?

(for example, treatment is effective)

training on administration of vaccines, cervical cytology and caring for patients with long-term conditions such as asthma, diabetes and coronary heart disease. The GPs also gave tutorials on specific conditions.

There was a process in place to ensure appropriate action was taken to manage poor performance.

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 these communications, including when staff were absent. Out-Of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received.

Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. 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.

Emergency hospital admission rates for the practice were comparable with national figures . The practice was commissioned for the unplanned admissions 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). The practice held monthly 'Avoiding Unplanned Admission' meetings with the multi-disciplinary team to discuss patients with complex needs.

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.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record to 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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Other health care professionals, including midwives and district nurses were able to access this system.

Consent to care and treatment

We found that 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.

Patients with a learning disability and those living 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. When interviewed, 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 the Gillick competency test and had received training updates regarding this following a significant event. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

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 discussion about the relevant risks, benefits and possible complications of the procedure.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

We noted a culture among the practice staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 48.45% of patients had been offered the health check. This was better than the national target rate of 40%. The data also showed that 22% of patients in this age group took up the offer of the health check.

The practice had many ways of identifying patients who needed additional support in giving up smoking, and was pro-active in offering additional help. For example, the practice had actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success compared to other GP practices and national figures.

The practice's performance for the cervical screening programme received a score of 84.5% which was above the national average score of 77.09%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

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 was above average for the majority of immunisations where comparative data was available. For example:

- Childhood immunisation rates for the vaccinations given to under twos ranged from 75% to 91% and five year olds from 82% to 97%. These were above clinical commissioning group and national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from 2014, a survey of 102 patients undertaken by the practice's patient participation group (PPG)(a group of patients registered with a practice who work with the practice to improve services and the quality of care) in March 2013 and from the friends and family test conducted between October 2014 and June 2015.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 92% and national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 91% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%

Patients completed 21 Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. All completed cards contained detailed positive feedback about the service experienced. Patients appreciated the continuity of care. Patients said they felt the practice offered an excellent, caring, friendly service and named individual staff as being efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 17 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. We received two emails from members of the PPG whose opinions matched these.

We saw 100 results from the friends and family test carried out since October 2014; 88 of these said they would be extremely likely or likely to recommend the practice. Five results said they would be unlikely to recommend the practice. The main area of feedback was not being informed of when there was a delay to see the GP or nurse. Positive feedback mirrored the feedback on CQC comment cards and included praise for the staff, ease of making an appointment and being treated with respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded which helped keep patient information private. Additionally, 97% said they found the receptionists at the practice helpful compared to the CCG average of 91% and national average of 87%.

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:

- 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 94% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 81%. These findings were also good for nursing staff.

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.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. The practice had also translated the practice information leaflet into the five most popular languages used. These included Polish, Turkish and Bengali.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 90% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the patient information 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 and systems were in place to routinely refer carers to the carers support network and to written information available for carers.

The GPs explained that they took an individualised approach when their patients had suffered bereavement but it was usually the patient's own GP who contacted them or visited them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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, two GP partners took on lead roles with prescribing particular medicines relating to substance misuse.

The practice had responded to the need to provide a service to patients with a learning disability as part of a direct enhanced service contract. Practice staff had access to a learning disability awareness training module through their online training software. The practice had introduced 'easy read' guides on subjects including contraception, cervical screening, healthy lifestyle and smoking cessation. Specific video links on the practice website showed more vulnerable patients what to expect when they attended the practice. For example, a GP had also introduced a you tube link on the practice website of 'what to expect when you visit' to help anxious patients prepare for a visit to the surgery.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included changes to the patient questionnaire and introducing colouring books and crayons for children to use.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The practice had also worked with a learning disabilities charity and champion to make the practice more user friendly. Changes included improved signage and the introduction of 'Easy Read' literature to help patients with anxiety or learning disabilities.

Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. There were adjustable examination couches to enable patients with restricted mobility to be examined. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There was a system for flagging vulnerability in individual patient records. Staff told us that they did not currently have any patients who were of "no fixed abode" as these patients had accessto a specialist practice in the city. Staff gave assurances they would welcome a patient if they came to the practice asking to be seen and would register the patient so they could access services.

There were male and female GPs in the practice; therefore patients could choose to see either.

The practice provided equality and diversity training through e-learning. Records confirmed that they had completed the equality and diversity training in the last 12 months.

Access to the service

The surgery was open from 8am to 6pm Monday to Friday. Outside of these times phone calls and the service are transferred to Devon Docs Out Of Hours service as part of a local agreement. Appointments were available from 8.30am and 6pm. Appointments could be made in advance or on the day for emergencies. The GPs also offered telephone consultations and were able to book to see these patients throughout the day.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the Out of Hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term

Good

Are services responsive to people's needs?

(for example, to feedback?)

conditions. This also included appointments with a named GP or nurse. Home visits were made to a number of local care homes by a named GP and to those patients who needed one.

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

- 93% described their experience of making an appointment as good compared to the Clinical Commissioning Group (CCG) average of 83% and national average of 73%.
- 77% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 71% and national average of 65%.
- 92% said they could get through easily to the surgery by phone compared to the CCG average of 84% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, we spoke with two patients who had telephoned the practice on the morning of our inspection and were seen within two hours.

Listening and learning from concerns and 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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. For example, there was information on the website and posters displayed within the practice. 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 17 complaints received in the last two years and found that these had been satisfactorily handled, dealt with in a timely way and with openness and transparency. We saw that patients were informed of any action taken and were given an apology when required.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. These included changes to systems and policies.

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. The administration team had designed the mission statement for the practice. The vision and practice values were part of the practice's strategy and business plan.

We spoke with members of staff and they all knew and understood the mission statement and understood their role in achieving this.

Governance arrangements

The practice was structured and well organised. There were policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at five of these policies and procedures, all had been reviewed annually and were up to date and most staff had completed a cover sheet to confirm that they had read the policy and when.

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 the senior partner was the lead for safeguarding. We spoke with 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 GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the QOF performance data which showed the practice was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. For example, a complaint had resulted in a change of policy and further education for staff. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example risks to staff when using visual display units. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held a programme of meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed at management meetings, staff meetings and quarterly meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies and found they contained current guidance. We were shown the electronic staff handbook that was available to all staff, which included sections on employee grievances, job security and stress at work. Staff we spoke with knew where to find these policies if required. The whistleblowing policy was available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

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

We saw from minutes that staff meetings were held every quarter and then followed by the practice quarterly meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. Staff said there was a sense of 'team' and that they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through

Are services well-led?

Good

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

the patient participation group (PPG) (a group of patients registered with a practice who work with the practice to improve services and the quality of care), surveys and complaints received. It had an active virtual PPG which included representatives from various population groups; older people, those with long term conditions, working age patients and family members. The PPG members we spoke with and received emails from said they were listened to and changes were made to parking, the appointment system, seating and information screens. One PPG member said that they felt the organisation seemed to have changed and added that there were far fewer patients waiting for their appointments in the waiting room and most only have a very short time before they were seen. Parking spaces had been increased and the Friends of the Practice group information screen provided valuable interaction.

We also saw evidence that the practice had reviewed results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a review of the staff personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was progressive in the use of modern technology. For example, 21% of patients had signed up to the practice 'app' where they could book appointments, order repeat prescriptions and access further information. Patients could contact the practice by email and book appointments and repeat prescriptions on line. Patients could sign up for text appointment reminders and test results. The GPs could access some hospital test results and were able to receive electronic communication from the hospital and Out Of Hours providers.

The practice was a GP 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.

The practice were part of the South West Primary Care Research Network and were inviting patients to be recruited to two current research projects for depression and diabetes.