Lifton Surgery

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lifton Practice on 12 May 2015. This was a comprehensive inspection. The practice is based at Lifton Surgery and provides general medical services to people living in the village of Lifton and surrounding villages in Devon. The practice has a dispensary on site, which we inspected. The practice has two branches at Lewdown village Hall and Bratton Clovelly village hall, with weekly sessions held on a Monday, for the treatment of simple conditions. We did not inspect either of these branches at this inspection. The practice provides services to a diverse population, covering an area of approximately 250 square miles.

At the time of our inspection there were 3386 patients registered at the service with a team of two GP partners. Lifton Surgery is a training practice. When we inspected there were no medical students on training placements at the practice.

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.

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 good for providing services to older people, vulnerable people and people with mental health needs including dementia, people with long term conditions, families, babies children and young people and working age people.

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

- Patient satisfaction was higher than the national average Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients. A named GP and practice nurse monitored the health and well being of older and vulnerable patients with a learning disability and/or complex mental health needs.
- 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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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. Patients reported high levels of satisfaction and confirmed that routine and urgent appointments were available the same day and staff were flexible and found same day gaps for patients needing routine appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Audits were used by the practice to identify where improvements were required. Action plans were put into place, followed through and audits repeated to ensure that improvements had been made.

We saw an area of outstanding practice including:

- The practice is the sole provider of general medical services to an adult social care nursing home for 24 patients with Huntington's Disease (a complex progressive neurological disease). Huntingdon's Disease is rare and opportunities to develop expertise across the county are limited for medical staff. One of the GP partners has developed expertise in caring for patients with this disease and works closely with a national centre for long term conditions providing expert advice to this centre. Patients with Huntington's disease from across the UK are referred to this service.

The practice should

- Set up a Patient Participation Group to engage patients in the on-going development of the service.

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. There were enough staff, and recruitment practices ensured that staff were fit to work at the practice or safe to carry out chaperone duties.

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 National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Lifton is a training practice and the quality of training and support provided was rated highly by the medical students on placement from Plymouth and Bristol Medical Schools. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. One of the GPs had nationally recognised extended expertise in treating and care of patients with Huntingdon's disease. Within the area including North Devon there is a high concentration of patients diagnosed with Huntingdon's disease when compared nationally. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams, which included strong links with other health and social care professionals supporting patients at the end of their lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed patients rated the practice higher than others for some aspects of care. Twenty nine CQC comments cards reviewed and discussion with seven patients on the day all provided positive feedback. A common theme was that the staff were extremely person-centred and patients were always treated with respect and compassion.

Summary of findings

Staff we spoke with were aware of the importance of providing patients with privacy and offered a room away from the reception area to discuss confidential matters. Information was available to help patients understand the care available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

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. Flexible appointments were available and arranged with patients to meet their needs. This included appointments outside of normal opening hours by arrangement for working age patients. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was reviewed and acted upon.

Are services well-led?

Good

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

It had a clear vision and strategy, which focussed on providing a family doctor service for multigenerational families living in the village and surrounding areas. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. 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 practice did not have a patient participation group (PPG) and GP partners were trying to set one up. 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.

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. There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients nearing the end of their lives. Patients were experiencing proactive management of emergency and short term pain relief medicine by reviewing this with the patient at intervals suited to their needs. This helped carers avoid having to travel long distances for these medicines.

Patients with complex care needs were well monitored by the practice working in partnership with other agencies. They were responsive to the needs of older people, and offered GP home visits and rapid access appointments for those with enhanced needs.

GPs were proactive in reducing risks associated with poly pharmacy for older people. For example, patients prescribed multiple different medicines had been frequently reviewed and changes made to reduce these.

Information systems enabled the practice to appropriately share important clinical and social information about patients with complex needs. This facilitated continuity of care for those patients.

Pneumococcal vaccination was provided at the practice for older people. In 2014, the practice had provided flu vaccinations for patients over 65 years. The practice population consisted of high numbers of farming families recognised as being stoical and rarely presenting at the practice for care or treatment, which affected the uptake for vaccinations. Shingles vaccinations were also provided to patients who fit the age criteria. Patients were contacted to offer them the opportunity to make an appointment to have the vaccination, which had increased the uptake of patients being given this.

The practice held regular carers clinics and works with a community support worker to provide additional help for carers.

Summary of findings

The practice worked in collaboration with local day centres and the Tavistock area service which included a befriending service for people. Vulnerable patients were signposted to these services and this was done compassionately and patients in this position were treated with dignity.

People with long term conditions

Good

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

The practice nurse had a lead role in chronic disease management and had dedicated appointments set aside to review patients with diabetes, asthma and/or chronic respiratory disease. Patients at risk of hospital admission were identified as a priority. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice held multidisciplinary meetings every month to review the needs of all patients with complex long term conditions.

Longer appointments and home visits were available when needed. Home visits for patients newly discharged from hospital were undertaken jointly with the community nursing team to carry out an assessment and arrange additional support where needed. All patients newly discharged from hospital were contacted or visited within 48 hours.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be carried out at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by some patients we spoke with as it avoided them having to travel to the opthalmology clinic based at the main hospital some 35 miles away.

The practice had links with the external health care professionals to provide advice and guidance as required. GPs and the practice nurse attended a quarterly virtual Diabetic clinic with hospital specialists, to review patient care and treatment. These staff also had expertise in certain areas, for example a GP was nationally recognised for their expertise in the care and treatment of patients with Huntington's disease. The practice nurse held additional diploma qualifications for more complex treatments for minor illness, diabetes and leg ulcers.

Summary of findings

Health education around diet and lifestyle was promoted by the practice. The practice took an early intervention approach and helped identify and signpost patients to external support. This included assistance with smoking cessation.

Families, children and young people

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. Appointments were available outside of school hours and the premises were suitable for children and babies. The waiting room had toys for children to play with whilst waiting for their appointments.

Emergency processes were in place for acutely ill children, young people and pregnant women with acute complications.

The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance. For example, close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided.

Young people had access to information about sexual health matters and could request chlamydia screening and be seen by either a GP or practice nurse of their choice.

Support was being accessed for parents from children's workers and parenting support groups where relevant.

Parents with children attending the practice in feedback cards confirmed that they were always present during consultations. Staff understood Gillick principles with regard to assessing whether a young person was able to understand and therefore consent to treatment. Parents told us that all of the staff engaged well with their children so that they found it a positive experience when attending the practice for appointments.

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).

Summary of findings

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had online facilities which enabled patients to book appointments and repeat prescriptions on-line. The practice website offered information about the full range of health promotion and screening available for this group. For example, the practice took a flexible person centred approach. Where needed appointments were offered to working patients outside of normal opening hours by arrangement. Over the course of two months, 13 patients had been seen outside of normal opening hours. Appointments were available for patients to see a GP, practice nurse or health assistant. Patients would be able to request repeat prescriptions on-line within a month, at the local pharmacy or in person at the practice. Repeat prescriptions were being given for up to six months.

Overseas travel advice including up-to-date vaccinations and anti-malarial drugs was available from the practice nurse within the practice with additional input from the GP's as required.

Opportunistic health checks were being carried out with patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks including blood tests as appropriate, and reminders to have medication reviews.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability and their carers for reviews. Home visits by GPs were carried out where needed to patients living in a newly opened adult social care home. The practice had liaised with the learning disability nurse specialist and was in the early stages of working with them to ensure information was communicated in a person centred way, for example in easy read or picture formats.

Shared care arrangements were in place for patients with complex mental health needs. The practice worked closely with the community mental health team and regularly reviewed each patient. Every patient had a care plan and risk assessment, which was reviewed.

Summary of findings

Health education, screening and immunisation programmes were offered as appropriate. This included alcohol and drug screening. Patients with alcohol addictions were referred to an alcohol service for support and treatment and to the local drug addiction service.

The practice worked closely with the community matron to arrange visits to vulnerable patients to assess and arrange any equipment or other assistance needed by the patient and their carers.

Systems were in place to help safeguard vulnerable adults. The practice welcomed all patients to the practice and had systems in place to temporarily register and communicate with homeless people.

Carer checks were carried out and the practice hosted a carer support worker clinic every month to support patients.

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 with dementia).

Flexible services and appointments were available, which enabled patients experiencing poor mental health to have longer appointments up to an hour at quieter times of the day, avoiding times when people might find this stressful.

Staff were skilled in recognising and responding to patients experiencing mental health crisis, providing support to access emergency care and treatment. The practice worked collaboratively with the community mental health team and consultant psychiatrists from the mental health partnership trust.

The practice had a list of patients with known mental health needs and worked to engage them in healthy living programmes. Each appointment with a patient was seen as an opportunity to screen patients and signpost them to additional services. In house mental health medication reviews were conducted to ensure patients received appropriate doses. For example, patients taking lithium had regular blood tests to ensure safe prescribing.

Advice and support was sought as appropriate from the psychiatric team with referrals made for psychiatry review or entry into counselling. Patients could refer themselves or be referred directly to the depression and anxiety counselling service, which ran one session per week. The practice had recognised that demand for this was increasing and was funding private counselling sessions for patients at the practice. In total, 14 patients had been seen by this service over the last 12 months in a total of 64 face to face sessions and 1 telephone session had been held. Information about

depression, including a diagnostic questionnaire was available on the practice website for patients to see and use. Patients found this helpful and made them more aware of when to seek help from their GP.

Early identification of patients with suspected dementia were being screened and referred to the memory clinic for diagnostic tests. GPs worked closely with the NHS memory clinic, consultants and other mental health workers specialising in care of older people. Data showed the practice was above the clinical commissioning group average of 93% at 96.7% in diagnosing people with dementia. Patients had care plans in place, which supported their on-going changing needs and those of their carers. The practice worked closely with a social centres in and around Tavistock and Launceston to provide services to support patients experiencing poor mental health.

Summary of findings

What people who use the service say

The practice sought feedback from patients in several ways. Three surveys, including the 2014 national GP survey showed that results for Lifton Surgery was better in all areas compared to the clinical commissioning group (CCG) and national average. Patient satisfaction was much higher than the national average, 98.2% compared with 86% in the 2014 GP survey. National survey data showed overall patient satisfaction was higher at 96.02% compared with the national average of 85.76%. Overall 93.49% patients found it easier to get through to the practice compared with the national average of 75.4%.

The practice had provided patients with information about the Care Quality Commission prior to the

inspection. Our comment box was displayed and comment cards had been made available for patients to share their experiences with us. Thirty six patients gave feedback at the inspection, in person (7) or in writing (29). All confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

In written feedback, the overarching theme from patients in their responses was that received compassionate care from all of the staff at the practice. They told us that staff took time to listen and often went beyond what was expected of them. GPs were described as being committed and passionate about what they do. Patients told us they were confident about the advice given and medical knowledge of their GPs. Access to appointments and the length of time given was described as a high point by patients who told us they never felt rushed. Patients were positive about the continuity of care they received from the team. Some patients were also carers and told us they received excellent support, which helped them care for their loved ones.

Parents told us the staff treated their children with respect. We were told the staff were good at communicating with children and young people, which in turn helped reduce any anxieties they might have had about visiting the practice. New parents said the GPs were always reassuring, which helped them become more confident in parenting their children.

Patients felt listened to and told us they had no complaints. They showed us information about how to make complaints, which was clearly displayed and told us they were confident that if they did have any concerns they would be acted upon.

Patients were satisfied with the facilities at the practice. The building was highlighted as being accessible for people using mobility aids, safe, clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients told us they found it easy to get repeat prescriptions and could often pick these up from the dispensary on site the same day or next day.

The practice did not have a Patient Participation Group (PPG) and GPs were considering various ways of setting this up. However, patient feedback was sought in three different ways via the national GP patient survey, a practice in house survey and on-going Friends and family test. Results of these were published in the practice waiting room and on the website. For example, GPs had improved they way they explained tests and treatment and had reviewed the appointment system in light of patient feedback.

Areas for improvement

Action the service SHOULD take to improve

- Set up a Patient Participation Group to engage patients in the on-going development of the service.

Summary of findings

Outstanding practice

- The practice is the sole provider of general medical services to an adult social care nursing home for 24 patients with Huntington's Disease (a complex progressive neurological disease). Huntingdon's Disease is rare and opportunities to develop expertise across the county are limited for medical staff. One of the GP partners has developed expertise in caring for patients with this disease and works closely with a national centre for long term conditions providing expert advice to this centre. Patients with Huntington's disease from across the UK are referred to this service.

Lifton Surgery

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 another specialist advisor who was a practice manager.

Background to Lifton Surgery

The GP partnership run the practice from Lifton Surgery and provide general medical services to people living in the town of Lifton and the surrounding villages.

At the time of our inspection there were 3386 patients registered at the practice. There is a higher percentage of patients over 55 years when compared to national statistics. The practice is placed within the mid range of the social deprivation scale.

The practice is contracted to provide general medical services, which includes maternity and pre-conceptual care, contraception, cervical smears, child health services, child immunisation and travel vaccinations and minor surgery. Lifton Surgery works in close collaboration with three other larger practices, where patients are referred to for specific women's healthcare including coil fitting.

There are two male GP partners, who held managerial and financial responsibility for running the business. Lifton Surgery is a training practice, with one GP partner approved to provide vocational training for medical students from Plymouth and Bristol medical schools. There were no medical students on placement when we inspected the practice. The GPs were supported by a registered nurse, dispensary manager and dispensers, other administrative staff including reception staff.

Patients using the practice also have access to community staff including community nurses, health visitors, and midwives. NHS funded counselling is available on site at the practice, as well as privately funded counselling provided by the practice which patients are referred to by their GP.

Lifton Surgery is open from 8.30 am - 6pm Monday to Friday, with clinic sessions running from 9 am to 12.30pm and 3.30 pm to 5.45pm. A walk in clinic runs every Friday between 3.30 pm and 5.45 pm. Flexible arrangements are offered for working age patients following consultation with patients and appointments are offered before and after clinics into the early evening by arrangement. The dispensary opens every day between 9 am and 5.30 pm. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Northern, Eastern and Western clinical commissioning group, which includes an arrangement for the Out of Hours service to take calls from 6pm.

Patients with minor conditions also have access to two small branches held at Lewdown village hall every Monday at 12 midday. On the 1st and 3rd Monday of the month patients can see a GP at Bratton Clovelly village hall at 3pm. Telephone appointments are available with both the GPs and practice nurse. Home visits are available for vulnerable, sick patients by arrangement.

During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Northern, Eastern and Western Devon clinical commissioning group.

The nearest minor injuries unit is based at Launceston hospital and information about this is provided for patients on the practice answerphone out of hours.

Detailed findings

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 12 May 2015.

During our visit we spoke with two GPs, the practice nurse, dispensary manager and dispenser administrative and reception staff. We also spoke with seven patients who used the practice. We observed how patients were being cared for and reviewed 29 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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Staff were readily able to locate this information and describe learning and changes made.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we reviewed these. Significant events were discussed as they arose when the two GP partners met every evening and the formal review process was a standing item on the practice meeting agenda every three months. Minutes recorded actions from past significant events and complaints. Learning from significant was shared verbally with relevant staff and changes made. Staff knew how to raise an issue for consideration at the meetings and were encouraged to do so. They told us that minutes of meetings, plus documentation for each SEA showing learning areas were accessible to all staff on the practice intranet.

Staff used incident forms on the practice intranet and sent completed forms to the GP partner who was also registered as the manager . He showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. An example was discussed, in which a perceived delay in diagnosis of bowel cancer arose. The practice had learnt from this event and educated its staff and introduced copies of the Bristol stool chart to be used in consultations with patients.

National patient safety alerts were disseminated by email to practice staff and action taken to deal with these. We were shown copies of these on the practice intranet which was accessible to all staff. For example an alert highlighted increased cardiovascular risks related to the prescribing of a particular medicine. The practice undertook a search for patients who were on this particular medicine following the alert and where appropriate had discontinued or given an alternative medicine. Staff told us that the particular medicine was now only prescribed to patients for short courses and patients were closely monitored whilst on it.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. The practice had policies and procedures providing staff with guidance about identification of suspected abuse and the processes for reporting this. The policy for safeguarding children referred to 2006 national documents and had not been updated to include guidance from the document 'Working Together 2013 and Intercollegiate Guidelines 2014' and the Royal College of GPs Safeguarding Toolkit 2014. However, discussions with staff demonstrated that they were following these principles in practice.

Training records showed that all staff had received relevant role specific training on safeguarding. GPs, the practice nurse and administrative staff were able to describe 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.

The practice had appointed specific a GP partner as the lead 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. Both GP partners had completed training at level 3 for safeguarding vulnerable children. The All staff we spoke with were aware who the lead was 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 linked with other siblings and family members registered at the practice. GPs were using

the required codes appropriately on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. For example, a GP partner highlighted the close working they had had with social services for a child in need and children on a interim care order which resulted in frequent contact when concerns were identified.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. 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. The practice nurse and other named staff had been trained to be a chaperone. Some of these staff worked in the dispensary. The practice had obtained a disclosure and barring check (DBS) for all the staff performing chaperone duties. We saw records showing that advice from the DBS had been obtained and risk assessments completed, which highlighted that this should be done in line with their role and responsibilities.

Medicines management

The practice had a dispensary at Lifton Surgery, which we inspected. We found that medicines were managed safely and there was clear accountability and governance of this service. A GP partner was the named prescribing lead. He had oversight of all processes and handling of medicines in the dispensary and was supported by a dispensary manager who worked closely with the CCG medicines optimisation team.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Staff records showed that training needs had been assessed for each member of staff. All of the dispensing staff, all had completed diploma level qualifications. A trainee dispenser was in the process of doing this qualification. Staff confirmed that as part of the appraisal process their on-going competency was assessed. Records also verified this and we saw that all of the dispensing staff had a competency assessment completed in March 2015.

Medicines were stored securely in the treatment rooms and medicine refrigerators and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice nurse and dispensing staff were responsible for monitoring these and knew the safe temperature range for storing medicines. Records for the previous month demonstrated that refrigerators were operating within the safe range described by staff. The dispensary was air conditioned and room temperatures were monitored so that it did not exceed the optimum temperature to store medicines at.

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

Records of practice meetings demonstrated that actions had been taken in response to reviews of prescribing data. We reviewed data which showed that prescribing patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were average when compared with local and national data.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up-to-date copies of both sets of directions and evidence that the practice nurse had received appropriate training to administer vaccines was seen. These included annual flu vaccination, including shingles vaccination and baby immunisations.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. GPs reviewed results and signed off any changes to dose, which were then communicated with the patient. As part of this process, patients were closely monitored to ensure they contacted the practice for their results so that they could be given advice about altering the dose of medicines they were taking. The practice had an additional monitoring safety system, which recorded when patients contacted the practice for results. Dispensing staff showed us these records and explained that if the patient was unable to give the current advised dosage, it was then escalated to their GP who would then arrange an appointment to see or discuss it with them.

Good

Are services safe?

Staff told us that this system had resulted in the team identifying emerging memory changes for at least two patients. For example, a GP had followed this up with a patient who had further investigations and was diagnosed with early dementia.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw the practice system, which ensured that all unused prescription forms were collected at the end of each day, signed back into the main record and stored securely until the next day.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) for dispensing at the practice. Standard operating procedures set out how they were managed. These were being followed by the dispensing staff. For example, controlled drugs were stored in a controlled drugs cupboard, access to these medicines was restricted and the keys held securely. The dispensing team had introduced easy to follow systems, which clearly distinguished the different classes of medicines, which required differing corresponding registers to be kept. We looked at these records and were able to audit who dispensed the medicines, to which patient and the name of the person collecting it. Staff told us they had introduced this system as a safety net should the need ever arise that and incident required reporting to the accountable officer at the clinical commissioning group (CCG).

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had established a service for patients to pick up their dispensed prescriptions at four locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

The premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The GP partner/registered manager showed us monthly audits they had completed. These showed where issues had been identified and action taken. In 29 comment cards, all of the patients remarked that they were satisfied with the standard of cleanliness at the practice. All seven patients we spoke with were also satisfied with the cleanliness and infection control at the practice.

The practice nurse supported a lead GP partner in managing all infection control matters. The practice nurse showed us their training certificates, which demonstrated recent updates completed about infection control matters. She told us that links with the local practice nurse forum were crucial for being made aware of changes and updates also. The practice nurse and lead GP partner had carried out audits for each of the last three years and improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and the actions implemented. For example, a trial of disposal privacy curtains had been started. We saw these in place in all of the consultation/treatment rooms and all curtains were labelled so that staff knew when to replace them within the six month period.

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. Staff showed us the practice intranet, which had been adapted by a GP partner to make it user friendly with links to key policies and procedures and online training and national guidance. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff described how they would use these to comply with the practice's infection control policy. For example, we saw there was a designated box for patients to put samples in and a protocol followed each time it was emptied. The practice nurse handled the samples, carried out checks and then safely disposed of the contents. The practice had a needle stick injury policy in place and staff knew the procedure to follow in the event of an injury. We saw the practice used needles with an integral safety sheath, which was in line with current practice.

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.

Good

Are services safe?

The infection control protocol made reference to other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessment. Recent changes had been put in place when staff attended an update with regard to the disposal of hazardous waste. Additional containers with a purple lid were being used for the disposal of cytotoxic waste. Records showed that the practice was following suitable procedures for the management, testing and investigation of legionella. This is a bacterium that can grow in contaminated water and can be potentially fatal. The practice was carrying out regular checks in line with national guidance to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records demonstrated this was happening. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and certain types of equipment were calibrated for accuracy for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The GP partner/registered manager verified that the practice had carried out a risk assessment and replaced all high risk equipment, such as mercury thermometers with digital versions.

Staffing and recruitment

Information provided by the practice showed that staff retention at Lifton was very high. All of the staff told us they enjoyed working at the practice. No new staff had been appointed since the practice came under regulation. However, the GP partner/registered manager showed us risk assessments they had completed for each member of staff. These looked at the role and responsibilities and highlighted the guidance followed and decision making around whether a Disclosure and Barring Service check was required. Appropriate checks had been undertaken in line with these risk assessments and the operating procedures at the practice in three electronic staff files we looked at. For example, all three files contained a criminal record check using the Disclosure and Barring Service (DBS). The practice had standard operating procedures covering recruitment, which included checks to be undertaken for temporary staff such as medical students and locum GPs. This stated that references had to be obtained from previous employers and immunisation, professional registration and indemnity insurance information checked at the point of employment. Records demonstrated that professional registration checks for the practice nurse were carried out annually and revalidation dates for GPs were known and being monitored.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for all members of staff to cover each other's annual leave and periods of sickness. A GP partner told us that the practice had only required locum GP cover on one occasion since 2006 and other staff confirmed this also. The two GP partners told us that they worked closely together covering the practice and collaboratively with two other large medical practices in the area.

Staff told us there were enough staff to maintain the smooth running of the practice and to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. All 36 patients we received feedback from, either in writing or in person, confirmed that they were satisfied with the staffing arrangements at Lifton Surgery.

Monitoring safety and 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and a GP partner was the identified health and safety representative. Records seen showed that appropriate checks were carried out, for example fire safety equipment had been tested in the last 12 months. Staff training records demonstrated that all staff had completed fire training, including a drill. The staff handbook showed that any new staff would receive an induction covering health and safety matters.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. In feedback cards, three patients specifically described their experience

of being treated when their health deteriorated. These patients commented that they were seen immediately, treated quickly and were reassured by the staff attending them. Staff gave us examples of referrals made for patients whose health deteriorated suddenly and this was supported by patients comments. For example, a patient had attended complaining of chest pains and was treated and reassured whilst waiting for emergency services to arrive.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records demonstrated that all staff had received training in basic life support in the last 12 months. 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).

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, suspected meningitis, hypoglycaemia, severe asthma, overdose, nausea and vomiting and epileptic fit. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of the medicines we checked were in date and fit for use. The practice nurse carried out these checks and was proactively managing when these medicines. The records showed when these medicines were due to expire and she told us they were ordered at least a month before when they needed to be replaced.

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. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The last fire drill had taken place six months previously in 2015. All of the staff listed on the training matrix had completed fire training in the previous 12 months.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff were able to give clear rationale for their approaches to treatment. They were familiar with current practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Weekly meetings were held at which the latest guidelines and research was discussed. The two GP partners also used their meeting at the end of the day to discuss any urgent changes to current practice guidance. Our discussions with the GPs and nurses demonstrated that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the latest NICE guidance about the management of patients with hypertension.

The GPs told us they lead in specialist clinical areas such as end of life care, huntingdon's disease, rheumatology and ear, nose and throat issues. The practice was the sole provider of general medical services to an adult social care nursing home for 24 patients with Huntington's Disease (a complex progressive neurological disease). Huntingdon's Disease is rare and opportunities to develop expertise across the county are limited for medical staff. One of the GP partners had developed their expertise over many years and was working closely with a national centre for long term conditions to share their clinical knowledge and provide expertise in this area. Patients with Huntington's disease were referred to the service from across the country.

The practice nurse had additional qualifications which allowed the practice to focus on specific conditions. For example, she held a diploma in asthma and chronic respiratory disease was responsible for managing the care of patients with these long term conditions. The practice did not run dedicated long term condition review clinics as they felt their patient numbers were too small for this to be an effective use of GP and practice nurse time. Instead long term condition reviews had taken place in routine GP and nursing appointments. Prior to the inspection, we identified some variances in the data for specific areas of monitoring of patients with long term conditions. We found that the practice had reviewed this data and set up registers of patients with each long term condition, which they were reviewing on a monthly basis. Patients were receiving invitations to attend for reviews around their birthday. As a result of this information, the practice had also considered reserving several appointments per week for these reviews. Data for the year 2014 to 2015 showed improvements on the previous year. For example, the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 9 months for 2013 to 2014 was 71.85%. In 2014 to 2015 the practice had exceeded the national percentage of 88% with 92%. Data showed that the monitoring of patients with diabetes had improved, but were still slightly below the average. Staff responsible for recalling patients fo these reviewed verified that patients with diabetes had been prioritised. GPs told us the review was designed to cover all possible issues in one appointment where possible.

Data from the local CCG of the practice's all were receiving appropriate treatment and regular review. performance for antibiotic prescribing demonstrated that this was comparable to similar practices (30% versus national rate of 28%). The practice had also completed a review of case notes for patients with high blood pressure which showed The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients every week and had on site meetings with other health and social care professionals supporting them.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data showed that the practice was performing well in preventing unplanned admissions for vulnerable patients (12.7% compared with national average of 13.6%). Data seen also showed that patients with suspected cancers were referred and seen within two weeks.

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. GPs told us the practice values were based on continuity of care for patients, whom they knew extremely well. Patients in written and verbal feedback gave us examples of this. For example, patients told us they were treated as individual's and their views respected.

Good

Are services effective?

(for example, treatment is effective)

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 reviews, and managing child protection alerts and medicines management. The information was then collated by a GP partner who was also the registered manager to support the practice to carry out clinical audits.

GPs showed us two clinical audits that had been undertaken in the last two years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For examples we looked at a completed clinical audit comparing patient experience of cancer diagnosis at Lifton Surgery against national figures as a benchmark. In the first cycle, 19 patients were identified within the parameters set which corresponded with a national audit. This looked at the number of visits a patient had made to the practice with symptoms attributable to the cancer prior to referral. The mode of referral (routine, urgent, 2 week wait or emergency admission) was then reviewed. The audit showed that the GPs were referring patients appropriately and minimising the delay in diagnosing patients with cancer. The second audit had the same outcomes for patients, in that GPs had referred fewer patients on the two week wait appointment system who did not have cancer but by the same token were not missing those who did have cancer and had appropriately referred them for assessment and diagnosis.

Minor surgery shows 100% compliance with obtaining consent and recording this in patient records over three years of audit between 2012 and 2014. Rates of complications from procedures such as wound infections were also audited and examined.Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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. For example, as a dispensing practice Lifton Surgery held regular meetings with the medicines optimisation team and had an agreed plan of dispensing review of use of medicines (DRUM). As a result of this, the practice had reviewed all patients taking four or medicines, which covered those with long term conditions and older people.

There was a protocol for repeat prescribing which was in line with current national guidance. Repeat prescription requests were reviewed daily and signed off by a GP. They also checked that all routine health checks were 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.

The practice had implemented the gold standards framework for end of life care. GPs told us that a high percentage of patients using the hospital needed palliative care support. The nearest hospices to the practice were a considerable distance away in Plymouth, Exeter and Truro, so both GPs worked closely with the palliative care team to support patients to be at home and receive services there. A palliative care register was held and reviewed regularly with the palliative care team. This included weekly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term medical conditions were offered a minimum of yearly health reviews. The practice had set up a new system to manage the recall process for these reviews with dedicated staff time for this. It was too early to report how effective this new system was or the impact for patients.

An annual flu vaccination programme was coming to an end when we inspected. The practice nurse explained that two pregnant female patients had booked to be immunised against flu. The practice had begun planning the next flu campaign for 2015/16 which would include older patients, those with a long term medical condition, pregnant women, babies and young children. For patients within the relevant age range a vaccination against shingles was also available and information about this highlighted in the practice and website. In 29 feedback cards and the seven patients we spoke with confirmed that patients requiring flu vaccination had been able to access it easily throughout the winter months. Patients were contacted via text, phone or email.

Data showed that the practice performance with regard to offering smoking cessation had improved over the course

Good

Are services effective?

(for example, treatment is effective)

of two years. By 2014-2015 100% of patients notes who were current smokers with physical and/or mental health conditions contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%.

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 74.51% which was comparable with the national average of 81.89%.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Lifton Surgery is a training practice providing placements for GPs and trainee doctors. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as teaching/training. Both GPs also had specific interests in developing their skills and disseminating this to the team. Both GPs confirmed they were up to date with their yearly continuing professional development requirements and all had revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

All staff undertook annual appraisals with a GP partner who was also registered as the manager, which included identification of individual learning needs. Mandatory training was provided on-line and some staff showed us their training records and paper portfolios with certificates of completed courses. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one member of staff told us they would be supported to complete an advanced qualification if they wished to proceed.

The practice nurse received their clinical appraisal from a GP at the practice. The practice nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. The nurse had received extensive training for her role, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines and undertaking cervical smears.

Working with colleagues and other services

GPs worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. There were policies in place outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. Both GPs were responsible for seeing these documents and results and for taking action required. Staff understood their roles and felt the system in place worked well and our observations supported this. Results and discharge summaries were followed up appropriately and in a timely way. For example, we observed a GP reviewing patient results immediately in between appointments and recording actions to be taken, which included contacting a patient for a follow up appointment. The practice had a safety net system in place, which meant that patient results and correspondence was only dealt with by permanent GPs working at the practice for continuity of care. A GP partner told us that locums were rarely used, with the last occasion being in 2006.

The practice worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children every month. Every three weeks there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team. The practice had a list of vulnerable adults and worked closely with community professionals. In two feedback cards, patients identified themselves as having learning disabilities and commented that they felt well supported and that their needs were met.

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

Good

Are services effective?

(for example, treatment is effective)

manner. Electronic systems were also in place for making referrals. Special notes were shared with the 111 and Out of Hours services for patients with complex needs who needed continuity of care and treatment overnight.

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. Each member of staff had a log in password, which could only be accessed by them. 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 promoting patient rights. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. For example, the team was developing links with a new adult social care service specialising in caring for people with learning disabilities. The practice nurse was due to meet the learning disability nurse specialist to get further guidance and support about desensitisation techniques to use when examining or treating patients. She said, this would also lead to developing information in picture and easy read formats to use when explaining procedures such as blood taking to patients.

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. Close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided. A parent we met during the inspection confirmed that they were always present during consultations. They told us that all of the staff were good at engaging their children and treating them as individuals.

Procedures were in place for documentation of 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 saw an audit of these which showed that consent had been recorded in 100% of patient records reviewed. The practice nurse showed us anonymised examples of where patient consent for procedures such as wound dressing, blood taking or cervical screening had been recorded.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. This was young person friendly and in easy read formats. The practice website contained information and advice about other services which could support them. The practice offered new patients a health check with a nurse or with a GP if a patient was on specific medicines when they joined the practice.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be taken at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by patients we spoke with who were in this position as it avoided them having to travel to the opthalmology clinic based at the main hospital in Plymouth or Exeter approximately 41 miles away.

There was information on how patients could access external services for sexual health advice. The practice provided confidential chlamydia screening and contraception.

Child immunisation rates at the practice exceeded national rates. Data showed that the practice had immunised 100% children aged 12 months, 24 months and five years.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

GPs said they aimed to promote patient dignity and respect in the way they approached requests for a home visit or repeat prescriptions. They told us they did so by overriding the normal triage system in place at the practice and assessed patients at their home. We observed a receptionist speaking with a patient over the telephone, who we later learned was frail and elderly. The staff reassured the patient that they would arrange for their repeat medication request to be dealt with quickly, passed onto the chemist and arrangements made for it to be delivered to them at home. The staff told us that this patient had told them they were unwell and could not get into town to collect their prescription and had been very worried about this. We saw the staff immediately ask a GP to review the request and approve it then saw them liaising with the chemist to dispense and deliver the medicines to the patient at home.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 29 completed cards and all were positive about the care and treatment experienced. Patients we spoke with (seven) said they felt the practice offered exceptional services and staff were caring, helpful and professional. They said staff treated them with dignity and respect. Patients were complimentary about reception staff and told us that every effort was made to give them a same day appointment even for routine issues. Our observations of reception staff responding in person with patients or over the telephone also confirmed this.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations and we did not overhear any conversations taking place in these rooms.

Staff understood the importance of being discreet when discussing patients' treatments in order that confidential information was kept private. They told us that they offered patients the opportunity to use a separate room to discuss any issues away from the reception area. We sat in the waiting room and observed patient experiences as they arrived for appointments. Reception staff were friendly and knowledgeable about patients and treated them with respect. However, it was possible to overhear the content of all of these conversations which we fed back at the end of the inspection. The GP partners told us they were aware of this and were considering whether to have background music on in the waiting area as a distractor.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were able to explain how they diffused situations to avoid further escalation of a patients frustration or anger. The locality had a violent patient scheme to which the practice could refer patients.

Care planning and involvement in decisions about care and treatment

Data showed that the practice was performing better with regard to maintaining a palliative care register for patients. GPs told us that treatment escalation plans were routinely discussed with patients on the register and their wishes about end of life care needs recorded. Minutes of multidisciplinary meeting demonstrated these were being followed for patients.

Patient survey information demonstrated that the practice achieved a better than expected level of patient satisfaction and involvement in planning and making decisions about their care and treatment. For example, national survey data showed overall patient satisfaction was higher at 96.02% compared with the national average of 85.76%. This was further verified in the discussions we had with seven patients and 29 comment cards we received with patient comments.

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being good at listening to their needs and acting on their wishes. Patients said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 29 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. Notices in the reception areas and information on the practice website explained the translation services

available in a number of languages. Practice staff told us they recorded this information in the patient record. Staff told us there were patients who spoke Polish but were accompanied by relatives who spoke English.

Patient/carer support to cope emotionally with care and treatment

The 29 comment cards we received were consistent in describing positive experiences about the care and treatment they had received. Patients highlighted that staff responded compassionately when they needed help and described as going beyond what was expected of them. The practice ran a monthly carers clinic in conjunction a community support worker, to provide practical and emotional support for patients who were carers. The practice signposted patients to the Tavistock Area Service and day centres.

Notices in the patient waiting room 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. Written information was also displayed in the waiting room explaining the various avenues of support available to carers.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. In 29 comment cards patients gave us several examples of the support received from practice staff when they had experienced difficult and challenging times in their lives. For example, an older patient was bereaved having lost their husband and had been visited at home by their GP and felt well supported.

Counselling services were hosted at the practice and run by the mental health trust. The practice paid for an accredited private counselling services for patients to address the needs of patients at Lifton Surgery, which were otherwise not being met.

Good

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, the low turnover of staff and size of the practice meant that the team knew their patients very well and this was highlighted each time we spoke with a patient or in the 29 completed comment cards. The practice also held registers for each group including one for vulnerable patients so that the support, care and treatment was patient centred.

The NHS England Area Team and 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.

Twenty nine patients commented that the prescription system was good. Patients could request repeat prescriptions online via the website, over the telephone or in person at the practice. We saw patients called in to collect their prescription from the dispensary at the practice. Some patients chose not to use the practice dispensary, instead opting to use a local chemist. The practice had systems in place to facilitate this for the patients concerned to ensure they received their medicines promptly.

The practice had arrangements in place for more vulnerable patients for example longer appointment times tailored to the patient's needs, which were typically up to one hour in length. The average appointment length was 15 minutes which was longer that most practices currently provide.

The practice did not have a participation group (PPG) when we inspected and was trying to set up one. However, the practice used three different surveys and the 'Friends and Family Test' to obtain feedback. The in-house survey had looked at the current appointment system twice over the previous two years. GP partners had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients via it's own surveys. For example, GPs had asked patients whether they wanted the practice to provide extended opening hours or continue with a flexible service which responded to individual needs. Patient feedback showed that they were satisfied with the current arrangements, which included a walk in clinic held every Friday afternoon. GPs provided us with further evidence of how they delivered a flexible service to patients, particularly those who were working and unable to attend appointments during the normal practice sessions. We saw that over the course of the last two years, 13 patients had been seen outside of the normal opening hours at a convenient time for them and the vast majority had been before surgery started.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed or were completing the equality and diversity training. All of the staff told us that equality and diversity was regularly discussed at staff appraisals and team events. GPs shared examples of how they used this learning in day to day practice. For example, they told us there were no barriers for homeless patients and workarounds were in place to record contact information should the need arise. The practice was in a rural location, with no nearby temporary campsites or transport links. GPs told us that because of this they had not had any homeless people using the practice.

The practice was situated on the ground floor. The practice had arrangements in place to ensure it was accessible for patients in wheelchairs with ramp access to the side of the premises. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was an accessible toilet next to consultation rooms, which included baby changing facilities and had a call bell system for help if needed. The practice had an audio loop in the waiting room for those with hearing aids.

The practice had systems in place to support patients whose circumstances may make them vulnerable. For example, the practice had a register of patients who may be living in vulnerable circumstances, with specific information in individual records about potential risks and support that was needed. This included patients experiencing domestic violence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us they tried to fit patients in for appointments if they presented on the day, making appointments accessible. Patients in 29 comment cards confirmed that this was also their experience of the appointment system.

Access to the service

Lifton Surgery is open from 8.30 am - 6pm Monday to Friday, with clinic sessions running from 9 am to 12.30pm and 3.30 pm to 5.45pm. A walk in clinic runs every Friday between 3.30 pm and 5.45 pm. Flexible arrangements are offered for working age patients following consultation with patients and appointments are offered before and after clinics into the early evening by arrangement. The dispensary opens every day between 9 am and 5.30 pm. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Northern, Eastern and Western clinical commissioning group, which includes an arrangement for the Out of Hours service to take calls from 6pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. New patients were given an information pack when they registered at the practice that included a booklet outlining all the services, names of staff, clinic times and out of hours information. Helpful advice about self management of minor illnesses was included, for example covering treating colds and coughs, indigestion and bruises.

GPs had published the results of an in-house survey carried out in November 2014, which looked specifically at the appointment arrangements. Patients were satisfied with these, including the online appointment system. The practice had longer than average appointment lengths and clinics rarely ran late. For example, the GP patient survey for 2014-2015 showed that 89% patients at Lifton Surgery waited less than 15 minutes to be seen for their appointment, which was better than the national average of 65%.

National patient survey data showed overall 93.49% patients at Lifton Surgery found it easier to get through to the practice compared with the national average of 75.4%. Seven patients we spoke with commented that receptionists were friendly and flexible when they rang to set up an appointment.

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.

In 29 comment cards, patients told us that GPs were very flexible, for example a patient told us their GP offered to see them early before morning appointments started as they had work commitments to get to.

The practice had flexible arrangements in place for working age patients. For example, GPs responded to individual needs and had seen 13 patients before or after clinics in the previous two months to accommodate patients who were working. Extended appointments enabled health screening to take place at one appointment avoiding the need for working patients to return for several appointments if they had multiple long term conditions. Repeat prescribing requests could be made by patients in some circumstances for up to six months as appropriate.

The practice used a triage system and offered telephone appointments for patients. Patients told us their GP usually telephoned them back after morning surgery or in between appointments, which they felt was a good alternative to attending in person for minor issues. There was a skill mix of staff, including the practice nurse with qualifications that enabled them to offer support to patients with long term medical conditions.

Longer appointments were also available for patients who needed them and those with long-term conditions. For example, patients with learning disabilities and/or mental health needs were offered appointments at quieter times of the day and for longer periods. Counselling services were available on site provided by the local mental health partnership trust but were limited to one session per week , which did not meet the needs of patients at the practice. Information was displayed in waiting areas for patients and highlighted they could self refer to these counselling services if they wished to.

An area of outstanding practice we saw was that the practice privately funded additional counselling sessions for it's patients to extend their access to talking therapies every week. A room at the practice was provided each week and GPs referred patients to the counsellor. The counsellor had successfully treated (seen for initial consultation, seen

Good

Are services responsive to people's needs?

(for example, to feedback?)

for further consultation(s) and then discharged as the problem had been successfully treated) 14 patients over the last 12 months in a total of 64 face to face sessions and one telephone session.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns, which was outlined in the practice booklet given to new patients as well as on posters in the waiting room and on the website. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice. We looked at complaints received from patients in 2013, 2014 and 2015, all of which had received a prompt acknowledgement and outcome in writing.

The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. Complaints had been analysed and there were no recurring themes. We saw the practice had held resolution meetings with patients.

None of the seven patients we spoke with, or 29 patients who gave written comments had ever made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager.

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. All seven staff we spoke to told us that Lifton Surgery was a family practice, which aimed to provide continuity of care to multi generations of local families registered with the practice. Staff were clear about their responsibilities in delivering the service and knew the patients extremely well. We found details of the vision and practice values were part of the practice's strategy and business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. Patients comments in person and in the 28 comment cards received confirmed this was their experience of the practice.

Staff morale was high and there was a low turnover of staff. As a training practice, Lifton Surgery provided regular placements for medica students from Bristol and Plymouth medical schools for educational purposes. Part of the forward planning for the future included offering placements for qualified doctors and the practice was working closely with three other local practices to develop this. Staff said they felt valued and were encouraged to be innovative to deliver safe and effective care and treatment for patients. The practice team was managed in an open and transparent way.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. All of these were available to staff on the desktop on any computer within the practice. The GP partner/registered manager verified that they used the NHS information governance tool kit. The tool kit was developed by the Department of Health to encourage services to self assess so that they could be assured that practices, for example, have clear management structures and responsibilities set out, manage and store information in a secure, confidential way that meets and data protection. We looked at some of these policies and procedures, which included those covering safeguarding, infection control, recruitment all of which had been regularly updated in light of changing guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, a GP partner and practice nurse took the lead for infection control and a GP partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, knew there was a whistleblowing procedure and who to go to in the practice with any concerns. Staff showed us the practice intranet, which made policies procedures and other guidance accessible. They told us had been adapted and made user friendly by one of the GP partner's and that additional guidance was made available to them. For example, staff in the dispensary had asked for further guidance about inhalers prescribed for patients with respiratory conditions and had an icon on their desktop to current guidance.

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 and in some instances better than expected 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. Prior to the inspection, data for the year 2013 to 2014 showed some areas where the practice was performing slightly under the average when compared with CCG or national rates. These included the monitoring of patients with diabetes, lifestyle assessment of patients with mental health conditions, flu vaccination rates for patients over 65 years and monitoring patients with hypertension. The data for 2014-2015 showed improvement in all of these areas and the practice had implemented a new system to recall patients for reviews with dedicated staff time to manage this process.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. These included systems to monitor the effectiveness of auditing and enabled the practice to consistently drive improvement.

The practice had arrangements for identifying, recording and managing risks. Risks were 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, a fire safety risk assessment had been reviewed in 2015. A fire drill was identified as an area for action and one had been done in May 2015.

Are services well-led?

Good

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

Leadership, openness and transparency

Meetings were held regularly and minutes kept and circulated via email to the team. 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 every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, induction policy and management of health and safety which were in place to support staff. For example, the practice had risk assessed each role and set out the expected standards for pre-employment checks for each position at the practice. This included what was expected should the practice need to use locum GPs and included making checks of the performers list held by NHS England and entries on the General Medical Council register.

Seeking and acting on feedback from patients, public and staff

The importance of patient feedback was recognised and the practice used three methods to do this. The national GP patient survey, in house survey and Friends and family test was used to obtain on-going feedback. For example, the practice had collated comments obtained through the Friends and family test between November 2014 and March 2015. This showed a total of 131 patients had made comments during this period. From this, GPs were able to determine that patient satisfaction was very high. All of the patients commented that they would be extremely likely to recommend the practice to friends and family if they needed similar care or treatment

Evidence provided prior to the inspection demonstrated that the GPs acted on patient feedback. For example, the practice had published a report about the GP patient survey for 2015 on the practice website. This highlighted that GPs used feedback from the previous year to improve the service for patients. In 2014, 75% of patients in 2014 felt the GP was good or very good at explaining tests and treatment. GPs at the practice set about improving this and in 2015 the results were 95% in 2015. Similarly only 76% of patients in 2014 felt that the GP was good or very good at involving patients in decisions about their care, again in 2015 patient feedback showed increased satisfaction to 91%.

In November 2014, the practice carried out an in-house patient survey. The results were also published on the practice website. The GPs showed willingness and flexibility to review the appointments available. For example, they shared with patients that they had the option of increasing availability of same day appointments at the expense of routine pre bookable appointments and would keep this situation under review. During busy times (after bank holidays and on Mondays) the practice was offering more same day appointments by reducing the number of pre bookable appointments on those days.

The practice did not have an active patient participation group (PPG) and was exploring different options with patients to develop one.

Management lead through learning and improvement

A random selection of four staff files showed that annual appraisal were carried out. Competency was assessed and training needs were identified, present conduct discussed and future plans agreed upon. The practice nurse showed us their portfolio which contained evidence of professional training and reflection on specific issues. Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by a line manager with the appropriate skills, qualifications and experience to undertake this role.

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurse are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, the practice nurse held records of anonymised cervical screening results. This showed 2.26% of all cervical smears had been rated with an 'indequate result', which was within the safe maximum allowed. External mentoring and support was provided through the cervical screening service where needed to improve skills and accuracy with such testing.