Bideford Medical Centre

Quality Report

Bideford Medical Centre
Abbotsham Road
Bideford
EX39 3AF
Tel: 01237 476363
Website: www.bidefordmc.com

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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 Bideford Medical Centre on 20 June 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there were urgent appointments available the same day. The practice deployed a dedicated “Same Day” team of GPs and a receptionist to make this happen for patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The practice offered carpal tunnel and vasectomy surgery.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff, patients, and external stakeholders, which it acted upon.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

Summary of findings

- The practice had acted upon the findings of its previous CQC inspection in November 2014. This included the provision of Mental Capacity Act 2005 training for all staff.
- A wide range of external stakeholders including district nurses, community matrons, health visitors, school nurses and community nursery nurses visited the practice during our inspection and all provided us with positive feedback about the practice.

We saw areas of outstanding practice:

Patient's individual needs and preferences were central to the planning and delivery of tailored services. For example, the provision of a dedicated "Same Day" team of GPs and a receptionist in addition to the practice GP team, the provision of a nurse practitioner run clinic minor illness clinic, for patients of all ages including babies. Patients were able to book an appointment and be seen the same day. This was provided five days a week.

The practice employed two clinical pharmacists, one partially funded by a clinical commissioning group (CCG) pilot scheme which ends November 2017 and the other is part of the national phase one clinical pharmacist pilot for three years. When the local initiative and national pilot end their posts will be funded entirely by the practice, in order to improve the service for patients. Their role was to check patient's prescriptions were safe, effective and appropriate. They discussed patient's different options such as blister packs and dosette boxes with separate compartments for days of the week to help patients maintain their medicine dosage accurately and safely. They checked hospital discharge summaries to identify required changes. They also liaised with external professionals such as care home staff, community matron and community nurses to review safe delivery and usage of medicines.

The practice recognised the challenge of communicating with teenagers. There was a dedicated teenager's section on the practice website which offered advice and signposting to relevant services such as contraception and sexual health services. The practice worked locally with other practices to raise awareness of teenage pregnancies and accommodated poor timekeeping by some teenagers. Practice policy was to always book in young patients when they asked, recognising their courage in coming to the practice.

The areas where the provider should make improvement are:

The practice should ensure that audit systems are maintained to monitor the risks of infection.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- Although the practice had completed regular infection prevention control (IPC) checks, these had not been formally recorded in writing for over 12 months. We were provided with evidence that a written infection prevention control (IPC) annual audit was completed within 48 hours of our inspection.
- All required emergency medicines were present.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice had acted upon the findings of its previous CQC inspection in November 2014. This included the provision of Mental Capacity Act 2005 training for all staff.
- End of life care was coordinated with other services involved.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the nurse practitioner ran a clinic for minor illness, for patients of all ages.
- The practice provided vasectomy surgery and carpal tunnel surgery on site.
- The practice employed two clinical pharmacists, one partially funded by a clinical commissioning group (CCG) pilot scheme which ends November 2017 and the other is part of the national phase one clinical pharmacist pilot for three years. When the local initiative and national pilot end their posts will be funded entirely by the practice, in order to improve the service for patients.
- There was a dedicated teenager's section on the practice website which offered advice and signposting to relevant services such as contraception and sexual health. The practice worked locally with other practices to reduce teenage pregnancies and accommodated poor timekeeping by some teenagers.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available and evidence from seven examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were clear about the vision and their responsibilities in relation to it. We received positive feedback about the practice leadership from staff at every level, stakeholders and patients.
- The strategy and supporting objectives were stretching, challenging and innovative, whilst remaining achievable.
- The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. Systems were in place to manage complaints. In seven examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- The leadership drove continuous improvement and staff were accountable for delivering this. Safe innovation was celebrated. There was a clear proactive approach to anticipating and meeting future challenges and embedding new ways of providing care and treatment.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. For example, with Devon Doctors Out of Hours service and the South West Ambulance Service NHS Foundation Trust. The practice used a secure computer system to share information effectively.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example, the practice liaised closely and worked with occupational therapists and the Bideford Hospital Enablement team to carry out home visits and assessments.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of registered patients with diabetes whose blood sugar tests within the last 12 months fell within acceptable ranges was 86%. This was better than the CCG average of 80% and the national average of 78%.The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

Summary of findings

- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

- The practice provided a weekly clinic at a local boarding school and also enabled pupils to attend the practice in confidence should they wish to do so.
- Active engagement with young people took place on the practice social media Facebook page. The practice website provided several pages of information targeted at young people, for example pages on sexual health and birth control options.
- We received positive feedback about the responsiveness of the practice from school nurses, community nursery nurses and health visitors who highlighted the approachability and interpersonal skills of practice GPs and nurses with young people.
- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital. The midwives were co-located at the practice and provided patients with this support.

  Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, the provision of ante-natal, post-natal and child health surveillance clinics in the provision of these services.

Summary of findings

- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours, minor illness clinics.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice maintained a website and a Facebook social media page to enable people to keep up to date with services provided by the practice.
- The practice provided vasectomy surgery and carpal tunnel surgery on site.

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 homeless people, travellers and those with a learning disability. Patients with a learning disability received annual health checks and the practice used pictorial methods of communication with them where appropriate.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

- The practice carried out advance care planning for patients living with dementia.
- 85% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.
  The practice specifically considered the physical health needs of patients with poor mental health and dementia. The practice assessed patients prior to referral to a local memory clinic run by Devon Partnership Trust.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 87% of patients with schizophrenia, bipolar affective disorder and other

  psychoses who had a comprehensive, agreed care plan documented in the

  record, in the preceding 12 months compared to the clinical commission group (CCG) average of 87% and the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice offered quarterly depot injections (used to systematically release medicine slowly over a long period) and had systems which provided a safety net to follow up patients who had failed to attend or cancelled appointments.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2017. The results showed the practice was performing in line with local and national averages.220 survey forms were distributed and 119 were returned. This represented 0.8% of the practice's patient list.

- 88% of patients described the overall experience of this GP practice as good compared with the CCG average of 90% and the national average of 85%.
- 84% of patients described their experience of making an appointment as good compared with the CCG average of 85% and the national average of 76%.
- 91% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 90%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards which were all positive about the standard of care received. Patients described a well organised service with friendly, approachable and professional staff.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The NHS Friends and Family survey results for April 2017 showed that of the 73 respondents, 92% were extremely likely or likely to recommend the practice to their friends and family.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that audit systems are maintained to monitor the risks of infection.

Outstanding practice

Patient's individual needs and preferences were central to the planning and delivery of tailored services. For example, the provision of a dedicated "Same Day" team of GPs and a receptionist in addition to the practice GP team, the provision of a nurse practitioner run clinic minor illness clinic, for patients of all ages including babies. Patients were able to book an appointment and be seen the same day. This was provided five days a week.

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pregnancies and accommodated poor timekeeping by some teenagers. Practice policy was to always book in young patients when they asked, recognising their courage in coming to the practice.

Bideford Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an Assistant Inspector.

Background to Bideford Medical Centre

Bideford Medical Centre is situated in the coastal town of Bideford, North Devon.

The practice provides a primary medical service to approximately 15,076 patients of a diverse age group. The 2011 census data showed that majority of the local population identified themselves as being White British. The deprivation decile rating for this area is five (with one being the most deprived and 10 being the least deprived). Public health data showed that 3% of the patients are aged over 85 years old which is similar to the local average (CCG) of 3% and higher than the national average of 2%.

There is a team of ten GP partners, two female and eight male; the partners are supported by four salaried GPs, a sessional surgeon and a GP registrar. Some GPs worked part time making the whole time equivalent GPs 9.5. Partners hold managerial and financial responsibility for running the business. The GP team were supported by a practice manager, deputy practice manager, IT manager, a reception manager, six practice nurses, a nurse practitioner/prescriber, seven health care assistants, two clinical pharmacists and additional administration staff.

Patients using the practice also have access to community matrons, community nurses and midwives, mental health teams, RISE counsellors (Recovery and intervention service for drug and alcohol support), school nurse and health visitors who are co-located on the same site as the practice. Bideford hospital was also located on the same site. Other health care professionals visit the practice on a regular basis including a hospice nurse and Parkinson's disease specialist nurse.

The practice is open from 8.30am to 1pm and between 2pm to 6pm Monday to Friday. Appointments are offered between 8.30am until 1pm and between 2pm and 5.30pm. Extended hours are offered every Tuesday from 7am until 8am and 6.30pm until 7.30pm. On a Wednesday and Thursday extended hours are offered 7am until 8am. Outside of these times patients are directed to contact the out of hour's service and the NHS 111 number.

The practice offers a range of appointment types including face to face same day appointments, telephone consultations and advance appointments (four weeks in advance) as well as online services such as repeat prescriptions.

The practice has a Personal Medical Services (PMS) contract with NHS England.

This report relates to the regulatory activities being carried out at:

Bideford Medical Centre

Abbotsham Road

Bideford

EX39 3AF

We visited this location during our inspection.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as Healthwatch to share what they knew. We carried out an announced visit on 20 June 2017. During our visit we:

- Spoke with a range of staff including the practice manager, deputy manager, practice nurses, GPs, reception and administration staff and spoke with five patients who used the service.
- We also spoke with a wide range of external stakeholders who visited the practice on the day of our inspection. This included community nurses and matrons, health visitors, school nurses and community nursery nurses. All external stakeholders provided us with positive feedback about the practice.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of seven examples over the last 12 months we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice sent these reports to NHSE every quarter for shared learning purposes.
- An example of a significant event occurred when a patient, with their family present, collapsed in the waiting room. The receptionist activated the alarm button and clinical staff from the practice attended to the patient immediately. Practice staff deployed the equipment from their emergency trolley and administered CPR (cardio pulmonary resuscitation). An ambulance was called and further treatment was provided. The ambulance crew, coroner and the patient's family praised the prompt actions of the practice staff. The practice held a shared learning session following this incident to discuss the actions taken and provide support to staff who needed it.
- We reviewed safety records, incident reports, patient safety alerts such as MHRA alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events. For example an MHRA alert about a diabetic medicine called canaglifzin alerted the practice about potential side effects. The practice searched and found three patients on this medicine. The practice GPs saw these patients and made changes to their treatment to reduce the risks of these side effects.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident where immunisations had not been returned to the fridge, the practice introduced a new process and a regular stock check at the end of each immunisation clinic. This improved patient safety and also provided confirmation that the correct immunisations had been provided to the correct patient on each occasion, and that sufficient immunisations were available for future clinics.
- The practice also monitored trends in significant events and evaluated any action taken. The practice held a quarterly significant event meeting to discuss and share learning from these incidents. We saw evidence in the form of meeting minutes that the most recent meeting had taken place in May 2017.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for child safeguarding and another lead GP for adult safeguarding. From the sample of four documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses and Health Care Assistants (HCAs) were trained to level two.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. The practice carried out DBS on all staff at the practice with the exception of cleaning staff. (DBS checks identify

whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were weekly and monthly cleaning schedules and monitoring systems in place. However, we found that the daily cleaning schedule had not been signed off on a daily basis. This was rectified when it was brought to the attention of the practice manager.
- There was an infection prevention control (IPC) protocol and staff had received up to date training. However, we found that infection prevention control checks had not always been recorded in writing. The practice provided us with evidence that this was rectified within 48 hours of our inspection. Findings identified by the audit were minor, for example a water stain on the floor which required cleaning.
- Regular hand washing audits of clinical staff were completed. All staff including reception and cleaning staff had received training in hand washing and infection control procedures.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure Barring Service.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the

treatment room. Emergency medicines such as glycerine trinitrate (used to relieve angina or chest pain) and aspirin were added to the emergency kit check list on the day of our inspection. We found that the general medicine stock list was not up to date. This was rectified immediately on the day of our inspection.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. This had been reviewed in September 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 96%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was better than CCG and national averages. For example, the percentage of registered patients with diabetes whose blood sugar tests within the last 12 months fell within acceptable ranges was 86%. This was better than the CCG average of 80% and the national average of 78%.
- Performance for mental health related indicators was similar to the CCG and national averages. For example 87% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in therecord, in the preceding 12 months compared to the CCG average of 87% and the national average of 89%.

There was evidence of quality improvement including clinical audit:

- There had been ten clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, for patients receiving methotrexate treatment (a medicine which required monitoring due to its side effects), prescribing had improved from 82% of prescriptions having clear and accurate wording to 98%. The benefit to patients was increased safety and accuracy.
- Information about patients' outcomes was used to make improvements such as: An anti-coagulation audit looked at patients who were in the therapeutic range (the range in which their condition could be treated safely with medicine). This audit has been done every six months over the last eighteen months, three cycles had been completed. The first cycle had found three patients in the therapeutic range less than 40% of the time. These patients were seen and their medicine altered to oral anti coagulants instead of warfarin medicine. The second cycle showed there was only one patient in range. The third cycle showed that there was only one patient (a different patient). The benefit to the patient of conducting these audits was that, if they were found to be outside the therapeutic range, then the risk of experiencing a stroke was higher. Measures could then be taken to reduce the risk.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, a practice nurse had been provided with specific training, funding and time to attend a course on minor illnesses. As a result this nurse was able to provide minor illness clinics to patients every day from Monday to Friday.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The practice provided training placements for two pairs of Physician Associates who were employed by neighbouring Bideford Hospital, in order to make the hospital more sustainable.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of four documented examples we reviewed we found that the practice shared relevant information with the North Devon hospice, Devon Doctors out of hours service and with the community matron in a timely way, for example when referring patients with complex care needs to these services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- The practice had acted upon the findings of its previous CQC inspection from November 2014. This included the provision of Mental Capacity Act 2005 training for all staff. We saw evidence that staff had completed this training between August 2016 to January 2017. This training was also discussed at staff meetings every quarter in addition to the provision of online e-learning on an annual basis. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Community Nurses, health visitors, midwives, school nurses, community nursery nurses, hospice nurses attended the practice on the day of our inspection. They told us that they met up with the practice regularly. GPs were reportedly approachable, and used a system for responding to messages. Practice reception staff were reportedly very helpful if external health professionals needed to book an appointment for patients immediately. Practice staff listened to and acted upon suggestions, such as referring a school child onto a specialist service. GPs often sought specialist advice from these health professionals. Quarterly safeguarding meetings with practice were effective, with a multi-agency referral process. Appropriate information sharing was used by the practice. Practice clinical staff liaised with school nurses if a school child had any risk factors. All of these external health

professionals told us that they felt part of the team. GPs were engaging with the Gold Standard Framework (GSF) for palliative care, all GPs attended at least one GSF meeting every other month.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet and referral to alcohol cessation support services. The practice HCAs provided stop smoking clinics every week.
- A dietician was available on the same site at the neighbouring hospital premises and mental health counselling was available from a local support group. The practice provided the counsellors with a private consultation room free of charge in order to support patients.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the CCG average of 82% and the national average of 81%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 98% to 99% (national average 90%) and five year olds from 96% to 99% (88% to 94% national average).

Patients had access to appropriate health assessments and checks. These included health checks for new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex should they wish to do so.

All of the 30 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with five patients including the chairman of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 87%.
- 86% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 92%
- 97% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 97% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared with the CCG average of 91% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, we spoke with the community matron who covered five practices in North Devon. They told us that staff at Bideford Medical centre were co-operative, responsive to concerns, good at liaison and understanding if GPs were interrupted. . The community matron provided us with examples of when the practice GPs responded positively to going out to do home visits in response to a request from the community matron. The community matron met with both practice nurses and GPs on a six monthly basis or more regularly if required. The community matron was also included in gold standard framework meetings which supported patients receiving palliative care.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. The practice recognised the challenges of communicating with teenagers. The practice provided a dedicated webpage on

Good

Are services caring?

their website and on a dedicated noticeboard provided relevant information such as sexual health and contraception. Receptionists were trained in signposting younger patients to relevant services.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 89% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 332 patients as carers (2.2% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

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

The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country. The practice's policy had been reviewed in June 2017. The practice had identified 14 military veterans which was 0.9% of their patient population.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours every Tuesday from 7am until 8am and 6.30pm until 7.30pm. On Wednesdays and Thursdays extended hours were offered between 7am until 8am. Consultations on extended hours had taken place with the patient participation group (PPG).
- The nurse practitioner ran a clinic for minor illness, for patients of all ages including babies five days a week. Patients were able to book an appointment and be seen the same day.
- The practice also deployed a dedicated "Same Day" team of GPs and a receptionist to make this happen for patients.
- The practice employed two clinical pharmacists, one partially funded by a clinical commissioning group (CCG) pilot scheme which ends November 2017 and the other is part of the national phase one clinical pharmacist pilot for three years. When the local initiative and national pilot end their posts will be funded entirely by the practice, in order to improve the service for patients. Their role was to check patient's prescriptions were safe, effective and appropriate. They offered patients different options such as blister packs and dosette boxes with separate compartments for days of the week to help patients maintain their medicine dosage accurately and safely. They checked hospital discharge summaries to identify potential discrepancies and liaised with external professionals such as care home staff, community matrons and nurses to review safe delivery and usage of medicines.
- The practice recognised the challenge of communicating with teenagers. There was a dedicated teenager's section on the practice website which offered advice and signposting to relevant services such as contraception and sexual health. The practice worked locally with other practices to reduce teenage pregnancies and accommodated poor timekeeping by some teenagers. Practice policy was to always book in young patients when they asked, recognising their courage in coming to the practice.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing aid induction loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Access to the service

The practice was open from 8.30am to 1pm and between 2pm to 6pm Monday to Friday. Appointments were offered between 8.30am until 1pm and between 2pm and 5.30pm. Extended hours were offered every Tuesday from 7am until 8am and 6.30pm until 7.30pm. On a Wednesday and Thursday extended hours were offered between 7am until 8am. Outside of these times patients were directed to contact the out of hour's service and the NHS 111 number.

In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were consistently higher than local and national averages.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 85% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 81% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 84% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 85% and the national average of 76%.
- 96% of patients said their last appointment was convenient compared with the CCG average of 95% and the national average of 92%.
- 82% of patients described their experience of making an appointment as good compared with the CCG average of 83% and the national average of 73%.
- 68% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 64% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice telephoned the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There were posters and leaflets in the waiting room which explained how to make a complaint should a patient wish to do so.

We looked at seven complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way. The examples demonstrated openness and transparency when dealing with the complaint. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

Complaints were discussed as part of significant event meetings every quarter. For example, an incident occurred where a receptionist was using two screens at the same time at reception, with the details of two patients, one on each screen. As the receptionist was dealing with a telephone call, they entered data into the wrong patient record. The data was a request for a GP to contact the patient. The patient complained that they never received a GP call back. Records showed that the practice manager had offered an apology and explanation in line with the complaints procedure and duty of candour. Shared learning from the incident included the importance of staff finishing one task prior to moving on to the next.

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 leadership, governance and culture were used to drive and improve the delivery of high quality person centred care. A systematic approach was taken to working with external stakeholders to improve care outcomes, tackle health inequalities and obtain best value for money. For example, by the employment of two clinical pharmacists as outlined above.

- The practice had a mission statement stating that they aimed to deliver consistent quality health care to its patients. This was displayed on the website and in waiting areas.
- The practice had formulated its shared purpose and agreed shared values. These included continuity of care, personal lists, care for and support patients, respect, value and support each other, open, democratic and fair, being a listening and learning practice. Staff we spoke with knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice held an annual away day to formulate strategies.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. There were GP leads for child and adult safeguarding, executive GP partner, Chair GP (for meetings, on rotation), Data Protection, Quality Outcomes Framework (QOF), education and training, minor surgery and all other clinical areas.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained.
- Partners meetings took place once a month and were also attended by the practice manager, deputy practice manager, salaried GPs and registrar GPs.
- Practice meetings attended by all staff were held as consultations prior to making major changes, such as introducing new computer systems or changing telephony systems which provided an opportunity for staff to learn about the performance of the practice.
- Departmental meetings took place monthly, these included reception meetings and treatment room meetings for nurses and health care assistants.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- We found that a written infection prevention control (IPC) audit had not been completed within the last 12 months. When this was brought to the attention of the practice management action was taken immediately. A written IPC audit was completed within 48 hours of our inspection. A new protocol was introduced to ensure this continued to achieve a complete audit cycle.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Significant event meetings took place both on an ad hoc basis following an incident, and also on a monthly basis.

Leadership and culture

The practice leadership nurtured and developed its staff, for example by enabling a receptionist to become a trained health care assistant and a practice nurse to train to become a nurse practitioner.

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of seven documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

Are services well-led?

Good

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

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with community nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held every 12 months. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the leadership and the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns. Rigorous and constructive challenge from patients, the public and stakeholders was welcomed. The practice obtained feedback via;

- patients through the patient participation group (PPG) and through surveys and complaints received. We met with the chair of the PPG. The PPG had approximately ten members and had run the group for the last ten years. The PPG met on a quarterly basis and carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had suggested that no charge be made for parking, this had been implemented. The PPG had also suggested the practice display information about methods of making an appointment; this had also been acted upon.
- the NHS Friends and Family test, complaints and compliments received. The practice had a compliments notice board on display in the staff area which contained numerous messages of thanks to the staff for an excellent service received from GPs, receptionists and other staff at the practice.
- staff through staff away days and through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff told us they had suggested changes to the deployment of reception staff during peak times. This had been implemented. Staff told us they felt involved and engaged to improve how the practice was run.

- Written feedback from Physician Associate who had completed training placements at the practice was positive and described the support they had received from clinical staff at the practice.

Continuous improvement

The leadership drives continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was a training practice and supported two GP registrars. The practice was part of the local and national clinical pharmacist pilots and had employed two clinical pharmacists in order to improve patient care and reduce risks to patients.

The practice was also involved with the hospital care home team, whereby if the practice felt a patient needed home visits to avoid hospital admission then they would arrange this in liaison with the care home. The practice ran a clinic at a large residential care home to support patients there on a weekly basis.

The care home team pilot included a nurse and a paramedic, working together to prevent unnecessary hospital admissions.

Are services well-led?

Good

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

Following our inspection on 20 June 2017, on 3 July the practice achieved a green impact for health bronze award from the centre for sustainable healthcare.