The Clock Tower Surgery

Quality Report

The Clock Tower Surgery
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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

The Clock Tower Surgery, which is run by Devon Health Limited was inspected on Wednesday 3 December 2014. This was a comprehensive inspection.

The Clock Tower Surgery is a unique primary medical service set up to provide access to health care for homeless and vulnerably housed people in Exeter. The practice provides support to help patients get back into main stream health and social care services as soon as their health and housing status is stable.

The practice provides primary medical services to a diverse population. At the time of our inspection there were approximately 563 patients registered at the service with a team of two salaried GPs. Devon Health Ltd runs the practice, which has a board and executive directors responsible for overall management and financial responsibility for the practice. Supporting the two GPs the team included a registered nurse, practice manager and administrative staff. We spoke with seven staff and two community mental health workers who worked closely with the practice team to support patients.

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

The practice is rated as GOOD. Specifically, we found the practice to be good for providing, effective, caring, responsive services and for being well led. It was also good for providing services for all population groups: 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 and people experiencing poor mental health (including people with dementia)

Our key findings were as follows:

- Patients reported high level of satisfaction with the care and treatment being offered to them. Several reported to us their health had improved as a result of this and felt the practice was unique and promoted equality and compassion.

Summary of findings

- Patients reported having good access to appointments at the practice and two GPs which improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients.
- The practice was seeking patient feedback daily as part of the 'Friends and Family Test'.
- The practice was well-led and had a clear leadership structure in place. There was an atmosphere of mutual respect and team work. There were systems in place to monitor and improve quality, identify business risk and systems to manage emergencies.
- The practice was responding to patient need. For example, funding had been secured to set up a Health, Wellbeing and Community Hub (HWCH) for patients within central Exeter presenting with complex needs. These include: drug and alcohol dependency, housing needs (homelessness), offending behaviours, access to primary health care services, access to employment and training, together with access to benefit and debt advice. This would provide services under one roof for patients and promote well co-ordinated care and support for them.

We saw several areas of outstanding practice including:

- Eighty three patients commented in person or in writing that the team was exceptional and genuinely cared about their welfare. For example, the practice had a clothing and bedding bank, which provided clean, warm clothing to any patients needing it. In cold weather, the team visited known areas of the city where patients were rough sleeping and offered warm drinks, additional clothing and bedding.
- The practice performance for carrying out cervical screening for female patients with complex mental health needs was well above the target set by the CCG.

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 safe services.

Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated to support improvement. Risks to patients who used services were assessed and systems and processes to address these risks were mostly implemented well enough to ensure patients were kept safe. Infection control arrangements had been audited and the practice was able to show whether improvements were effective and sustained. The practice managed the complex needs of patients well and responded in a timely way when urgent care and treatment was required.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patients received prompt, co-ordinated care across the GP and nursing team at the practice. Pathology results and scanned correspondence was consistently followed up and appropriate referrals made to specialists where necessary for patients. Systems were in place to ensure that all clinicians were up-to-date with both NICE guidelines and other locally agreed guidelines, which was influencing and improving practice and outcomes for their patients. We saw data that showed that the practice was performing as expected and improving vulnerable patient access to healthcare.

Are services caring?

Good

The practice was rated as good for providing caring services.

Patient survey feedback showed high levels of satisfaction and the number of registered patients was increasing. Seventy four CQC comment cards reviewed and discussion with nine patients on the day all provided positive feedback. A common theme was that the staff were compassionate and supportive in promoting the health and well being of patients. This was clear in the way staff engaged with patients with complex mental health needs. Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services.

Summary of findings

The practice was proactive in carrying out health checks before further prescriptions were issued to vulnerable patients. Patients confirmed this system worked well. The practice children and young people living at a secure care home run by the local authority. A named GP were monitored the health and mental well being of the children and young people. All of the staff were highly skilled communicators, which promoted the development of good rapport and continuity of care for patients.

Flexible arrangements were in place for appointments. There was a GP and nurse walk in clinic every day from 9.15 – 10.45am, with appointments from 10.45 – 12.15 and 2-5pm. The practice worked closely with other community health and social care workers, hosting specialist clinics every day from Tuesday to Friday each week for patients. Extended appointments were offered at quieter times of the day for patients who found it difficult to attend at busier times. Potential health risks for some patients had been identified and early interventions such as information about leading a healthy lifestyle or signposting to other services had taken place.

Patients reported good access, including same day appointments. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with staff and other stakeholders. Improvements as a result of the learning from complaints included greater awareness of the importance of handling sensitive information.

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 an accessible health service to vulnerable people. Staff were clear about the vision and driven to provide a compassionate and supportive service for patients. There was a clear leadership structure and staff generally felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought patient views and had started to collect daily feedback from them for the 'Friends and Family Test'. 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.

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, for example, in dementia and end of life care. Patients at risk of unplanned hospital admission had a care plan in place. It was responsive to the needs of older people, and offered home visits and rapid access appointments as well as a walk in appointment service to see a GP and or nurse every day.

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 patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. When patients attended the practice for the first time they had a named GP who with the support of the nurse carried out a raft of health screening checks. Patients were then offered an individualised plan, with structured reviews of their health and medicines whilst they remained registered at the practice. The frequency of reviews tended to be greater than in other primary medical services where patients had an annual reviews. 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.

Families, children and young people

Good

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

Children living in disadvantaged circumstances and who were at risk were quickly identified and measures to reduce these risks were put in place. The practice provided GP support for children and young people living in a secure service run by the local authority. This was a collaborative role and included screening and treating patients for chlamydia, blood borne and respiratory illnesses associated with living in disadvantaged circumstances. Access to contraception advice and support was also available to young people.

Summary of findings

The practice did not offer an immunisation service because the children of patients vulnerably housed were registered at other GP practices in the city.

Female patients presenting at the practice had access to midwifery services with set appointments every Tuesday. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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 practice offered accessible and flexible appointments. Each contact with patients was used as an opportunity to screen and prioritise existing and new health issues. Many of the patients attending the practice were vulnerably housed and did not have access to financial support through the benefits system or paid employment. Assistance was given to patients to help them access financial and housing support so that they might take the first steps towards having a more stable life.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people living in vulnerable circumstances.

The practice was rated as outstanding for the population group of people whose circumstances may make them vulnerable. The target group for the practice was patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities.

Homeless patients could access a GP from the practice without an appointment at the walk in clinic five times a week. They could also be seen by appointment at different times of the day if they preferred. The practice was responsive and saw all patients needing urgent assessment and treatment within minutes of arriving. The practice offered longer appointments for people with learning disabilities.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Patients were only referred on to register with mainstream GP practices when there was evidence that they were permanently housed.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

Staff knew their patients well enough to detect early signs of mental health relapse and worked closely with them to keep them safe. All these patients had a named GP and structured reviews to check their health and medicine needs were being met. Safeguards were in place to make sure that high risk medicines were identified and regularly monitored. The practice held a list of all patients on depot medicines, which included the date when it was last give and next one due. The list was closely monitored by the practice nurse and demonstrated that the team was proactive in engaging with patients on this medicine. Records showed medicines were given as prescribed, which was crucial in stabilising patient's mental well being so that they did not experience unnecessary hospital admission due to mental health crisis. Patients had experienced a discussion about their lifestyle, about their drinking and smoking habits. The practice performance for carrying out cervical screening for female patients with complex mental health needs was well above the target set by the CCG.

The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Shared premises enabled face to face discussions could take place and responsive support available when patients were in crisis.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency or were hospitalised where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

The practice had secured funding to set up a Health, Wellbeing and Community Hub (HWCH) for patients within central Exeter presenting with complex needs. These include: drug and alcohol dependency, housing needs (homelessness), offending behaviours, access to primary health care services, access to employment and training, together with access to benefit and debt advice. This would provide services under one roof for patients and promote well co-ordinated care and support for them.

Summary of findings

What people who use the service say

The 2014 patient survey results showed patients had higher levels of satisfaction with regard to their experiences of involvement in decisions about their care and treatment at the practice.

Eighty three patients commented in person or in writing that the team was exceptional and genuinely cared about their welfare. For example, the practice had a clothing and bedding bank, which provided clean, warm clothing to any patients needing it. In cold weather, the team visited known areas of the city where patients were rough sleeping and offered warm drinks, additional clothing and bedding.

The practice did not have a patient participation group but consulted with existing and potential patients through the homeless shelters and other support charities in Exeter. Quarterly surveys were carried out to obtain patient views to make improvements to the service. The practice had just implemented the friends and family test and was encouraging patients to give feedback daily after every consultation.

Outstanding practice

- Eighty three patients commented in person or in writing that the team was exceptional and genuinely cared about their welfare. For example, the practice had a clothing and bedding bank, which provided clean, warm clothing to any patients needing it. In cold weather, the team visited known areas of the city where patients were rough sleeping and offered warm drinks, additional clothing and bedding.
- The practice performance for carrying out cervical screening for female patients with complex mental health needs was well above the target set by the CCG.

The Clock Tower 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 specialist advisor, a Practice Manager specialist advisor and an Expert by Experience.

Background to The Clock Tower Surgery

The Clock Tower Surgery is a unique GP practice commissioned to provide access to NHS primary care services for approximately 563 homeless and vulnerably housed patients. The practice is situated in the city of Exeter and works closely with other mainstream GP practices, health and social care services.

The practice has two salaried GPs who are supported by a qualified nurse. The clinical team comprises of 1 male and 2 female staff. There is an administrative team consisting of a practice manager and a receptionists. The opening hours are: 9.15am to 5pm Monday to Friday. There is a GP and nurse walk in clinic every day from 9.15 – 10.45am, with appointments from 10.45 – 12.15 and 2-5pm. The practice works closely with other community health and social care workers, hosting specialist clinics every day from Tuesday to Friday each week. These provide patients with access to a midwife, consultant psychiatrist, heptology specialist nurse and a physiotherapist. Clinics are held twice a week for vulnerable patients in extreme mental health crisis. Emergency Out of Hours cover is delivered by another provider.

Devon Health Ltd is registered with three locations. This inspection focussed on the Clock Tower Surgery only. The practice does not have a dispensary, however patients are able to collect their medicines from a choice of pharmacies in Exeter.

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

We carried out our announced inspection at the practice on Wednesday 3 December 2014.

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.

This provider had not been inspected before and that was why we included them.

Detailed findings

Please note that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time. The Clock Tower Surgery had not been subject to the Quality Outcomes Framework so data was not available. Outcomes for patients were being monitored by NHS England and NHS Northern, Eastern and Western Devon CCG through performance reports produced by Devon Health Ltd. about the Clock Tower Surgery. The information from these documents has been referred to throughout this report.

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included information from NHS England, NHS Northern, Eastern and Western Devon CCG, Devon Health watch and the local council Health and Scrutiny Board. We looked at the 2014 patient survey and corresponding action plan the practice had in place. We carried out an announced inspection on 3 December 2014. During our visit we spoke with staff (GPs, a nurse, managers and administrative staff). We spoke with nine patients who used the service. We observed how patients were being cared for and reviewed personal care or treatment records of patients. We reviewed 74 comment cards where patients and members of the public shared their views and experiences of the service. We spoke with two community mental health workers linked to the practice who worked with staff to support patients.

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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice sent us a three year log of these from 2012 -2014. We looked at the records of a serious event audit (SEA) undertaken in February 2014. The practice instigated a review of events leading to a patient on a detoxification programme being discharged from hospital with highly addictive medicines. There was no learning for the practice, however it showed that the team were vigilant about patient safety and had raised awareness of this with the local NHS Trust.

NHS England told us the practice shared SEAs and serious incidents requiring investigation (SIRIs) with them, so was considered to have a good reporting culture. Staff confirmed that actions taken as a result were then reviewed at a later date to ensure change was embedded in practice and sustained. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were discussed at practice meetings agenda with a dedicated meeting occurring every three months to review actions from past significant events and complaints. The organisation running the practice also had a newsletter for staff, which raised awareness about learning and changes to practice. Staff including a receptionist, administrator and nurse were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Incident forms were available electronically. The general manager and practice manager monitored these and took action where necessary. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, one related to the delayed referral for investigation and treatment of a patient at hospital. The GPs we spoke with were open about their learning and showed us all of the documentation relating to this matter. Information was shared with other stakeholders, which helped facilitate the investigation and led to an action plan being developed to improve clinical practice.

National patient safety alerts were disseminated by email to practice staff and accessible on the practice intranet. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings held every two weeks for the whole team to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The team had clear oversight of patients who could be at risk of unplanned admissions to hospital, receiving palliative care or had complex care needs. The practice provided GP support for four hours per week at a secure care home for children and young people run by the local authority. We spoke with the GP responsible for covering this service who told us they carried out comprehensive assessments of the children and young people, which included consideration of potential risks. These were then discussed with the custodial team and plan put in place to reduce the risks and safeguard the child or young person.

They demonstrated a clear understanding of Deprivation of liberty safeguards (DOLS) and closely monitored patient experiences of restraint to ensure individual plans and procedures were followed at the care home.

All of the patients attending the practice were vulnerable due to their lifestyle. The team worked in close collaboration with other health and social care professionals to manage and review the risks with vulnerable patients. Two health care professionals working for another agency told us that the team at the practice identified potential risks for patients quickly and made appropriate referrals to them to provide additional support for the patients. Nine patients we spoke with described positive experiences at the practice, which they felt

promoted their safety. They told us the practice was responsive in providing treatment and additional support at times of crisis, which they said had reduced the risk of unplanned admissions to hospital.

Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. This GP said they were trained to level 3 for safeguarding children and had also completed adult safeguarding training. All staff we spoke with were aware who the lead was and who to speak to 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 so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Two examples were discussed with the safeguarding GP lead and nurse, both of which demonstrated that the practice worked collaboratively with the safeguarding board, parents and other health and social care professionals to protect the children involved. GPs had attended child protection meetings although in most cases the children were registered at another practice. Staff explained that patient records flagged concerning information and highlighted potential risks for vulnerable adults and children using a coded system. The safeguarding lead explained that the practice had identified vulnerable adults and worked closely with other health and social care professionals, including the GPs looking after a patient's child/children to protect them.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. The practice policy highlighted that only nurses and healthcare assistants carried out chaperone duties. Chaperone training had been undertaken by senior administrative staff. The practice had obtained Disclosure and Barring Service (DBS) checks for all the staff and had provided appropriate training for those involved in chaperoning. We spoke with staff who understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Medicines Management

Safe systems were in place for the generation of repeat prescriptions. Patients had a number of ways to request their repeat prescriptions, in person or by leaving a written request at reception. Repeat prescriptions were closely monitored in line with the individual patient's risk assessment and treatment plan. For example, patients undergoing detoxification were prescribed limited amounts of medicines on a daily or weekly basis for safety. This arrangement was agreed with the patient and dispensing pharmacy. The practice had a system to follow up patients who did not attend after which staff could not generate a repeat prescription unless the doctor had reviewed the prescription. Prescription pads were held securely and records held to show how these were used.

Medicines were stored securely at the practice and were only accessible to authorised staff. No high risk medicines were kept at the practice. Other medicines, for example vaccinations were stored at the required temperatures. Staff monitored the temperatures of medicines refrigerators to make sure these medicines were safe to use. The practice had a supply of emergency medicines. These were checked regularly by a named nurse to make sure they were in date and safe to use. Checks had also been undertaken to ensure that procedures were being followed.

Directions in line with legal requirements and national guidance were in place for the nurse administering vaccines. There were up to date copies of these directions, which staff demonstrated they followed. There was a refrigerator in the treatment room for any items requiring cold-storage and temperatures were monitored to ensure these medicines were stored correctly. . The nurse was responsible for carrying out this task showed us the stock control system in place and vaccines used for patients were within date. Information about flu vaccination was prominent in the waiting room. Nine patients told us they had been offered flu vaccinations when they presented at the practice.

GPs explained that home visits were rare. If medicines were required GPs said this was determined by patient needs and often none were required.

Good

Are services safe?

Cleanliness & Infection Control

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

The practice nurse was responsible for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received updates. We looked at a file of monthly audits carried out in 2014. Practice meeting minutes showed the findings of the audits were discussed with staff and changes made as a result. For example, learning from an SEA had also identified that the spill kit was missing from equipment and one had been obtained to deal with any spills of body fluids.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, the practice nurse told us they cleaned equipment used to test patients blood pressure and lung capacity after every patient. The majority of equipment used was single use.

Policies in place covered areas such as personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury, which linked with occupational support for staff in the event of an injury. Staff told us they had been made aware of the latest guidance about needles and were using safer equipment outlined in this document.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Records showed that the practice had been risk assessed by an external contractor. Action plans had been put in place following the assessment to reduce the risk of infection to staff and patients. Cleaning staff recorded weekly actions carried out to run the water supply to reduce risks and promote safety for staff and patients.

Equipment

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

Staffing & Recruitment

We looked at three staff records, all of which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only staff with a satisfactory DBS were approved to carry out this additional duty.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. For example, the nurse said they were never expected to work outside of their scope of practice. They shared examples of how their professional competencies linked with health promotion clinics being delivered. For example, the nurse had completed an advanced course about the management of addictive behaviours. Staff told us that holiday and unplanned leave such as sickness tended to be covered in house. Locum GPs and nurses could be obtained through an approved list. However, practice records showed that there had been two instances earlier in the year when no locum could be obtained and GP cover had to be provided by other practices for two afternoons. The general manager and practice manager told us staff cover was on the risk register as it had been recognised that the practice needed to establish a more reliable and responsive system to obtain

cover at short notice. New arrangements were being put in place with the expansion of services provided by Devon Health Ltd. All of the patients we spoke with and comment cards received were satisfied with the level of service at the practice.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records demonstrating that actual staffing levels and skill mix were in line with planned staffing requirements. GPs also responded to urgent needs from patients. This included making home visits where necessary. Nursing staff had a broad range of responsibilities and tended to see patients with more complex needs. For example, a joint visit had taken place when a patient was unable to attend the practice. Staff told us they had been concerned about the patient's welfare and believed the person was at significant risk of self harm. A GP, manager and community mental health worker assessed the patient, provided urgent treatment and resulted in the patient being admitted to hospital for their safety.

Monitoring Safety & Responding to Risk

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

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. Devon Health Ltd. had oversight of these processes and we saw that any risks and actions to reduce these had been discussed at practice meetings.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The crisis and intervention team were based in the same building. The practice staff shared examples with us which demonstrated they recognised potential triggers, changes in behaviour and managed risks. For example, a home visit had taken place to a patient who was in crisis and also at risk with their physical health. The team encouraged the patient to accept support, which resulted in them being admitted voluntarily for assessment at the local psychiatric hospital.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support, which was updated in 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The team had reviewed the contents of the emergency equipment alongside up to date guidance from the Resuscitation Council. Staff knew the location of this equipment. Records demonstrated that emergency equipment had been checked regularly and was in full working order.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Fire safety policies and procedures were in place and being followed. Weekly and monthly set checks of equipment had taken place. For example, the fire safety folder contained records showing that weekly alarm checks had been done throughout 2014. A fire risk assessment had been undertaken that included actions required to maintain fire safety. Records showed staff were up to date with fire training and a fire drill had recently taken place.

Good

Are services safe?

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. The practice had identified a potential risk with regard to covering unplanned absences. Being a highly specialised service, it was difficult for the practice to source suitably qualified and experienced locum cover during these times. There was an action plan in place, which linked with the expansion of the service and increased staff pool to draw upon in such events.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff demonstrated they followed current guidelines from the National Institute for Health and Care Excellence and from local commissioners. Devon Health Ltd. disseminated latest information to the practice staff through a monthly newsletter and intranet. The GPs told us they also reviewed new guidelines and discuss the implications for patients care at a twice monthly practice meeting. Guidelines were discussed and required actions agreed. For example, benzodiazepine prescribing practice had been reviewed in conjunction with NICE guidance.

The GPs told us they lead in clinical areas such as sexual health, emergency medicine, diabetes, heart disease and asthma. Each GP had undertaken additional qualifications, for example one GP had specialist qualifications in the care and treatment of substance misuse. The practice nurse had undertaken advanced courses covering sexual health and chronic disease, including asthma management. This enabled the practice to provide opportunistic screening for patients, which took account of their transient lifestyle. GPs and the practice nurse were skilled in engaging patients. Whenever they had contact with a patient, staff explained they tailored this to what the patient needed and helped to develop a rapport with them so that further health screening and treatment could be provided.

Data from NEW Devon Clinical Commissioning Group (CCG) of the practice's performance for prescribing pain relief was higher risk when compared with other practices. GPs explained the context of this data, which highlighted the complex needs patients presented with. For example, high number patients presented with multiple areas of infection due to their living conditions. Typically, patients sleeping rough had significant leg ulcers which required antibacterial treatment and on-going wound care. The GPs said they sought guidance from the optimisation team at the CCG and followed NICE guidelines.

The performance report which the practice submitted to NHS England showed that referral rates to secondary and other community care services for all conditions were comparable with other practices. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture at the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. We met nine patients with diverse needs who all said GPs referred them to specialists without hesitation when a second opinion was required. Patients had a holistic assessment when they visited the practice. In conjunction with health screening, this also included consideration of what other help a patient might need to improve their financial and housing situation. We saw a documented example of how a patient had been supported to obtain benefits and permanent housing so their quality of life and health could be improved.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. For example, safeguards were in place to make sure that high risk medicines were identified and regularly monitored. The practice held a list of all patients on depot medicines, which included the date when it was last give and next one due. The list was closely monitored by the practice nurse and demonstrated that the team was proactive in engaging with patients on this medicine. Records showed medicines were given as prescribed, which was crucial in stabilising patient's mental well being so that they did not experience unnecessary hospital admission due to mental health crisis.

These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and to support the practice to carry out clinical audits. GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the CCG. For example we saw an audit regarding the prescribing of analgesics and non steroidal anti-inflammatory drugs. Following the audit the GPs carried out medicine reviews for 11 patients who were prescribed these medicines, which found no changes were required. GPs maintained records showing how they had evaluated the prescribing practice and documented the success of this where possible. This had been challenging for GPs to follow up and was dependent upon patients continuing to be engaged with the practice as some chose to leave the area moving on with their transient lifestyle.

Good

Are services effective?

(for example, treatment is effective)

Other audits carried out looked at the success rates of patients who had detoxed from alcohol under the care of the practice. This showed that the level of support patients experienced influenced the degree of success they had in changing their drinking habits. The evidence from this audit was also used by the practice to develop a multiple agency protocol so that patients experienced better co-ordinated support across all agencies.

Nurses were also subject to clinical audit cycles and have to be revalidated every 3 years to carry these out. The practice nurse verified that the results of smear tests for female patients were always checked and followed up. 'Inadequate' smear test results led to the patient being recalled and additional audits being triggered. Records showed that there had been no inadequate results for the previous year. The last two performance reports submitted to NHS England showed that the practice was screening a higher percentage of female patients above the agreed target of 50%.

The practice also used information about performance against national screening programmes such as smoking cessation to monitor outcomes for patients. This data showed an improvement in the numbers of patients who were being offered smoking cessation services when compared to the previous year.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. GPs told us the review periods were set according to individual patient need. In some instances, prescriptions were reviewed weekly with vulnerable patients to promote continued engagement so they could be monitored more closely and given as much support as possible. The nurse and GPs all checked that routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. This showed GPs had oversight and a good understanding of best treatment for each patient's needs.

The GPs also worked collaboratively with peers working in similar practices across the country, which were few and provided specialist services. They shared their experiences and sought peer support about different approaches that could be taken to manage patients with complex and challenging needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Staff said they received support for their professional development. A good skill mix was noted amongst the GPs. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. GPs told us they informed the practice manager when they had been appraised. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the GMC can the GP continue to practice and remain on the performers list with NHS England.

All of the staff interviewed confirmed that annual appraisals were undertaken. These identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. In some instances this was also driven by the inadequacy of current community services, which did not meet patient needs and needed improvement. For example, one GP had completed specialist training in management of addictions so that the practice would provide a substitute prescribing service to help patients. The GP explained that patients addicted to street drugs were often caught up in a cycle of negative and unsafe behaviour so having access to a well co-ordinated substitute medicines service would help them move away from having to use potentially dangerous street drugs. Patients told us they looked forward to the practice being able to provide this as they felt it would help promote continuity of care. Other agencies involved in shared care arrangements for patients would then be able to focus on providing psychological and social support for patients.

The practice nurse had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. These duties included health screening and management of patients with long term conditions. Staff told us that baby immunisations were rarely carried out as other GP practices in the area had responsibility for overseeing the care of children of patients registered at the practice. There was a training matrix for the practice highlighting the core and specialist training expected for each staff role, which was being delivered.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

Close working with other community services was evident. For example, the community mental health team was situated in the same building and had daily face to face contact with staff at the practice about patients. Two staff working for another agency told us that important information about patient welfare was shared in a timely and appropriate way. Staff at the practice were described as being highly skilled, compassionate and motivated to provide access to comprehensive healthcare for patients who were vulnerable.

Twice a week, the practice provided consultation space and support for patients being seen through the violent patient scheme. This service was carefully co-ordinated between three teams from different agencies, including the practice and held at a quieter time in the afternoon. Safety measures were in place, which included additional staffing provided by the other agencies to promote a safe environment for patients to be seen. The purpose of the meeting was to monitor patients with complex needs who could be more at risk. This also included patients receiving palliative care who might need additional support from the hospice or for further advice from the palliative care consultant.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their records. Practice meeting minutes showed that multidisciplinary meetings were held and a standing item at every meeting was to carry out a clinical review of patients and manage identified risks. For example, the practice team received regular updates about a patient's whereabouts, which included custodial information from the prison service. The practice was developing a multi agency protocol with other GPs and the prison services to improve communication about transfer of health care for detained patients.

The practice used an electronic patient record system, into which results from investigations such as blood testing, letters from consultants and discharge letters from hospital were scanned in. Specific staff oversaw this process each day and created a task within the system for the patient's GP to review the results. There was a duty system in place for GPs to ensure that patient's results were reviewed every day and action taken where necessary.

Information Sharing

The practice used several electronic systems to facilitate continuity of care and treatment for patients. For example, there was a shared system with the local out of hours provider to enable patient information to be shared in a secure and timely manner. GPs showed us the system, which allowed them to upload special notes directly onto this system. An example shared with us involved the care of a patient prescribed complex pain medicine. Information was shared with the out of hours provider so that the medicines were managed safely to avoid risks such as potential overdose. The practice had a list of patients who were vulnerable, at risk due to long term conditions and those receiving palliative care. Electronic systems were also in place for making referrals to secondary care services.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. GPs and Nurses we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). One GP at the practice had responsibility for supporting children and young people being cared for at a secure care home run by the local authority. As part of this role, the GP carried out an assessment of needs within 48 hours of the child/young person being admitted to this service. In our discussions with the GP they demonstrated understanding of both Gillick competency assessment and the remit of the local authority as legal guardians for these children/young people. They were clear about deprivation of liberty safeguards (DOLS) and of their responsibility to monitor and report any concerns they might have. The GP confirmed that children and young people at the service experienced minimal restraint only when necessary and that this was appropriately recorded and followed agreed protocols.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed frequently. For example, staff explained how they were closely monitoring the welfare of a patient diagnosed with a life threatening disease and dementia who chose to continue to be a rough sleeper. The

Good

Are services effective?

(for example, treatment is effective)

practice set up an appointment schedule with the patient on the same day each week at the same time, place and with the same staff. This anticipated the risks associated with worsening memory for the patient and had created a set routine for the patient which they followed every week. Staff had been able to closely monitor the patient's health and welfare and had plans in place should they no longer have mental capacity to make decisions.

There was a practice policy for documenting consent for all interventions. For example, for wound care or cervical screening the practice policy was for a patient's verbal consent to be obtained and documented in the electronic patient notes.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were immediately followed up. We noted a culture amongst the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers. However, staff told us this had to be offered once a patient was comfortable and a rapport had been developed with them. The transient nature of patient's lives meant that other health issues needed to be prioritised for treatment over promoting changes to lifestyle.

The staff used various nationally recognised tools to identify potential long term health conditions. For example, an assessment of drinking habits highlighted that a patient was significantly at risk of liver damage due to the level of alcohol addiction. Help was offered to the patient quickly as well as further health screening, which resulted in greater awareness for the patient and referral to secondary services for urgent care.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The verbal and written feedback we received from 74 patients in total had common themes about their positive experiences at the practice. They highly praised all of the staff who work at the practice and described a culture that was centred on their needs. Patients talked of staff being professional, friendly, helpful and caring. We saw interactions between staff and patients, which demonstrated the staff were skilled in putting patients at ease.

Privacy and dignity were respected. At the reception desk we observed interactions between reception staff and patients. These were polite, professional and demonstrated staff were caring and knew their patients well. There was appropriate screening in consultation and treatment rooms. Patients said chaperones had been offered and sheets used to protect dignity during intimate examinations. There were notices informing patients of their right to have a chaperone should they want one.

Eighty three patients commented in person or in writing that the team was exceptional and genuinely cared about their welfare. For example, the practice had a clothing and bedding bank, which provided clean, warm clothing to any patients needing it. In cold weather, the team visited known areas of the city where patients were rough sleeping and offered warm drinks, additional clothing and bedding.

Care planning and involvement in decisions about care and treatment

The practice provided quality reports for NHS England, which included information about patient satisfaction and involvement in decisions about their care. The practice had carried out patient surveys every quarter to capture people's views. In the 2014 GP survey, 91% of patients reported that GP was good or very good at treating them with care and concern. Similarly, 85% patients reported that the GP was good at involving them in decisions. Both of these results were above national averages.

Patients told us they felt involved in the decisions about the care and treatment they received and were able to decline treatment. None of the nine patients we spoke with said they had ever felt rushed whilst seeing the GP's or nurse. All of the patients said they felt the GP really took time to listen and acted on their wishes.

We did not speak to any patients whose first language was not English. Staff told us there were facilities to access a telephone and face to face translation service should it be required. The team had a clear overview of patients on the practice list of current patients who might need translation services.

The practice and consulting rooms had level access. If any patients used walking aids they were able to move without any restrictions between the waiting and consultation rooms.

Everyone working at the practice was expected to sign a confidentiality agreement as part of their contract of work. Patients we spoke with were not concerned about confidentiality. They were aware their information sometimes needed to be shared by the GP or nurse with other healthcare professionals. The training matrix showed that staff underwent training on information governance (sharing confidential information).

Patient/carer support to cope emotionally with care and treatment

Practice survey information for 2013-14, which we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The nine patients we spoke with and 74 comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when extra support was required. Staff accessed psychological support for patients, where available and as appropriate. GPs told us they had raised concerns with another health provider about the availability of psychological therapies and had wanted to improve access for patients at the practice.

Notices in the patient waiting room signposted people to a number of support groups and organisations. The practice's computer system provided a facility for GPs to record if a patient was also a carer. This enabled prompts to be recorded to ensure their health was assessed as well as the demands of caring for their relative explored with them. GPs told us that the majority of patients registering at the practice had lost or chose not to be in contact with their family. Staff recognised this put patients at risk of social isolation so tried to quickly arrange additional support from other agencies and encouraged patients to take this up.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice responded to their individual health needs well. They said that preferences, such as to see a doctor of the same sex, were responded to where possible. Nine patients we spoke with consistently commented that their GP had an in-depth knowledge about their needs. Patients told us that the practice was reliable, particularly at times of crisis or when in urgent need.

There was a private room available where patients could speak with staff confidentially. This contained informal seating and a coffee table and staff told us it was also used if patients were particularly emotional when they attended the practice.

Seventy four patients in feedback cards commented that the prescription system was good. The practice had arrangements in place for more vulnerable patients so that prescriptions were sent automatically to the chemist of choice. The chemist then dispensed these direct to the patient. Contact details for patients were set up at the point of registration and checked at each visit. Some patients used mobile phones, whilst others gave refuge or shelters as the contact number/address. Reminders were telephone through or sent to patients via the contact address and health checks carried out before further prescriptions were issued. Staff were mindful about handling confidential information and were discreet when leaving a message for a patient to return a call to the practice. Patients confirmed this system worked well.

Secondary care referral to hospitals or other health providers were made promptly. Patients were able to pick their own routine appointment time through a choose and book system. For urgent referrals to other services GPs completed a template, administrative staff processed it and an appointment was booked.

The practice did not have patient participation group (PPG). The practice worked closely with homeless charities and services in Exeter supporting vulnerable people to obtain patient views about access to services. The 'Friends and Family test' was underway and we saw feedback forms being handed out to patients at the end of their appointment. This test allows practices to collect feedback daily from patients attending for appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning it's services. For example, the practice was promoting equality in the way it supported patients. Every patient we met during the inspection compared their experiences at the practice with other services. Patients said they felt staff treated them as equals and went beyond what was expected to help them improve their situation and health.

Managers and GPs were knowledgeable about changes in the local population in terms of ethnicity and diversity of patients registering with the practice. For example, every six months the practice collated information which was shared with NHS England to provide an overview of the age range, sex and number of patients registering with the practice. Manager's told us that the practice population had been growing as patient satisfaction levels were high. The practice had set up a move on protocol for patients to help them transition to mainstream GP services where ever they chose to settle. However, there were safeguards in place for patients which included having strong evidence that the patient had permanent accommodation before being discharged from the practice list. Once transferred to another practice, patients were followed up to ensure they had attended the new GP practice to register.

Equality and diversity training had been completed by all staff via e-learning. Staff we spoke with confirmed they had completed this training in the last twenty four months and that equality and diversity was regularly discussed at appraisals and team events. Our observations of how staff approached patients and the overall culture demonstrated that the team embraced the principles of equality and diversity in day to day practice.

Access to the service

Feedback cards completed by 74 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Nine patients we spoke with told us the appointment system was accessible, by telephone or bookable in person. A walk in service was available as well as set appointments every day. Appointment length was need-specific so GPs arranged longer appointments when they thought this was necessary. Longer appointments were routinely offered to some patients, for example patients with complex mental health needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Home visits were carried out where needed and usually in response to increase risks for a patient. For example, a GP and the practice manager had visited a patient who was in crisis and at risk of self harm. Community mental health workers told us the visit was well co-ordinated, responsive and had safeguarded the patient who needed urgent hospital admission.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. 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.

The practice demonstrated evidence of learning from patient complaints. Staff were able to describe the process and showed they were aware of this procedure. The practice analysed and reported on complaints to NHS England every six months. This showed the practice looked for potential themes and put actions into place, which were shared across the team to raise awareness and improve patient experience.

None of the nine patients we spoke with, or 74 patients who gave written comments had ever made a complaint. Patients were confident that if they did have any concerns they would be listened to and acted upon. Patients told us they felt comfortable with all of the staff and would speak to the receptionists, nurse, 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

There was clear leadership at the practice. Devon Health Ltd. provided clear business and clinical leadership in all areas at the practice. The organisation had a board and executive team, which included a medical director. Two salaried GPs employed at the Clock Tower surgery took the lead for particular areas such as safeguarding and specialist care. The majority of staff told us they felt they were well supported and enjoyed working at the practice. The changes and challenges staff faced at the practice related to the size of the team and unique service being delivered to vulnerable patients with multiple health issues.

Staff morale was high at the practice. We observed the team were driven in their desire to provide vulnerable patients with equal access to health services. Staff said they felt valued and were encouraged to do the best for patients. The practice team was managed in an open and transparent way at the practice.

Governance Arrangements

All of the staff we spoke with understood their role and responsibilities and demonstrated appropriate accountability in the way they supported and treated patients in their care. There were clear lines of accountability with regard to making specific decisions, especially decisions about the provision, safety and adequacy of the care provided and these were aligned to risk.

GPs had lead roles, for example one GP was responsible for the protection of patients. Policies and procedures underpinning Adult and Children safeguarding at the practice were kept under review by this GP and referenced national guidance and current local safeguarding processes. The adult safeguarding procedure lacked information about the practice policy regarding disclosure and barring checks for staff or use of disciplinary procedures in the event of concerns being raised about staff. Administrative staff held specific responsibilities for example with regard to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were escalated to the GP prescribing lead and were then discussed to raise awareness across the clinical team about potential risks and necessary actions to take.

The practice nurse told us they were supported through the local practice nurse forum and links with the modern matron and other specialist nurses at the Royal Devon & Exeter hospital. Devon Health Ltd had a lead nurse, who provided support and appraised the practice nurse each year. GPs were appraised by the medical director. All other staff were supported and appraised by the practice manager. Training needs were identified and support given to staff to undertake additional training to increase their skill base. There were management systems in place to monitor the quality of the service provided. Regular reports every six months were provided to the Northern, Eastern and Western Clinical Commissioning Group (CCG). This included performance information, clinical and strategic management. Referrals were monitored and there was a peer support system in place for GPs to check each others referrals and treatment approaches, for example, for appropriateness.

There were clear lines of reporting at the practice, which was clearly monitored through quality and safety processes. The team had a clear overview of the most vulnerable patients. Immediate, medium and longer term actions were in place to mitigate potential risks and promote patient safety, health and welfare.

Leadership, openness and transparency

GPs met every day to discuss practice issues informally with the rest of the team and there were regular formal meetings to promote good communication and team work. These included monthly meetings to review risks and issues arising for patients receiving shared care, at risk of unplanned admission or with complex care needs, twice monthly clinical governance and business meetings between the GPs, practice manager and general manager.

Practice seeks and acts on feedback from users, public and staff

The importance of patient feedback was recognised and the practice was operating the 'Friends and Family Test' to obtain people's views daily. The practice did not have a patient participation group (PPG) as it had proved difficult to engage patients with this in the longer term. In house patient surveys had been carried out every three months to obtain feedback about the practice and staff from patients.

The practice utilised other community services such as homeless shelters and other providers to consult with potential or on-going patients of the service.

Are services well-led?

Good

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

We met nine patients and collected 74 feedback cards from patients all of which highlighted that the practice sought their views about all aspects of their care and acted on these.

Management lead through learning & improvement

We saw evidence that the practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. For example, a GP had set up their own peer support group with other GPs and specialists working in the field of substance misuse and primary medical services for vulnerable homeless people. They were also funding private supervision to promote their own well being. We spoke with a senior manager about the supervision arrangements available for GPs at the practice. We were told GPs were able to access support from the medical director within the organisation at anytime.

A random selection of three staff files showed that annual appraisal were carried out. Training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff files 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.