Hill Barton Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Hill Barton Surgery on 7th July, 2015 as part of our comprehensive inspection programme.

We have rated the practice overall as providing a good service. Specifically we found the practice to be good for providing responsive, safe, effective, caring and well led services. It was good for providing services for all the population groups, older people, families, children and young people, people with long term conditions people in vulnerable circumstances, people experiencing poor mental health and people who are working age or recently retired.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- There were arrangements in place to respond to the protection of children and vulnerable adults and to respond to any significant events affecting patients' well-being.
- The practice worked well with other health care services to enable a multi-disciplinary approach in meeting the health care needs of patients receiving a service from the practice.
- The practice managed complaints well and took them seriously. Information about how to complain was available and easy to understand.
- There was a clear management structure with approachable leadership. Staff were supported and had opportunities for developing their skills, were well supported and had good training opportunities.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients commented how helpful the staff were in trying really hard to get them a convenient appointment.
- The practice had a vision and informal set of values which were understood by staff. There were clear clinical governance systems and a clear leadership structure in place.

However there were areas of practice where the provider needs to make improvements

Importantly the provider should:

- Introduce a system for Nurse meetings to be more formal and minutes taken with actions agreed.
- Introduce a system to ensure policies are reviewed and updated.
- Give consideration to improving the disabled toilet facilities.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Hill Barton was a small practice and as a consequence the staff and patients knew each other well, the patients we spoke with said they valued this relationship and were grateful for the care they received from all the staff. 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 easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The needs of the local population were reviewed and the practice engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. This was confirmed by the last GP patient survey which showed that 92% of 127 patients said they were able to get an

Summary of findings

appointment to see or speak to someone the last time they tried, this compares higher than the national average of 81%. The practice provided a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Early morning appointments were available from 7am twice a week to support those people who were working.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, although some needed to be reviewed and updated, they held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Older patients all had a named GP. All those who spoke with us had been offered regular health checks. The practice had provided care plans for the 2% of their adult patients at most risk of admission to hospital, in accordance with the direct enhanced service (DES) commissioning scheme. All patients discharged from hospital were reviewed within 72 hours. Special messages were attached to the computerised patient records that Out of Hours services could see, to ensure consistent care.

Monthly complex care meetings were attended by the practice manager and one of the GPs. All patients were discussed with their usual GP prior to the meeting to raise any ongoing issues. The practice worked closely with the Community Matron in caring for older patients and their holistic needs. The practice had a Palliative care nurse who visited the practice regularly and had immediate access to GP's to ensure timely intervention with the dying patient.

The practice used a Commissioning Intelligence website to help identify patients that had been admitted or discharged from hospital that day. This information was relayed to the GPs who then made contact with the patient once they were home. The practice made referrals, with the patients consent, to local charities and support groups, such as Clyst Caring Friends, Neighbourhood Friends and Age UK for patients in need of support such as befriending or help with bathing.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice managed the care of their patients with long term conditions using recall systems to ensure regular reviews of these patients.

The Practice Nurses carried out health reviews with patients suffering from long term conditions. For example those patients with Asthma and COPD (Chronic Obstructive Pulmonary Disease) hypertension, diabetes etc. Practice Nurses had received training to perform such reviews. Practice Nurses attended regular updates to enhance their knowledge of all long term conditions.

Special messages were attached to the computerised patient records that Out of Hours services could see, to ensure consistent

Summary of findings

care. If a patient was admitted to hospital, the practice sent a written summary to the hospital with details of both the current problem and of past medical history, including current medication and allergies, to enable consistency of care.

When necessary, home visits were made by GPs or community nurses to carry out reviews.

The practice extended hour's appointments allowed more convenient access to working age patients with chronic diseases.

Families, children and young people

Good

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

Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Weekly midwife led antenatal clinics were provided at the practice. The midwife had access to the GP if necessary. New mothers were sent appointments for their eight week check together with their child's first immunisations. All practice nurses were trained to give childhood immunisations and attended regular training to keep their knowledge up to date. Baby and child immunisation programmes were well organised and available to ensure babies and children could access the full range of vaccinations and health screening. These included the 8 week check for both mother and baby, along with the immunisation clinics. Last year's performance for child immunisations showed that 96% of one year olds had received all their primary vaccinations required.

The practice offered a full range of contraceptive services including emergency contraception. All nurses were trained in cervical screening and attended regular updates. Patients were proactively offered chlamydia screening.

There was an alert on the clinical system to identify patients on the Child Protection register; this was visible to all relevant staff. GP's had all undertaken appropriate child protection training.

Children were always offered an appointment on the day if an urgent appointment was needed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

Advance appointments (up to two weeks in advance for a GP and up to six weeks for a nurse) were available for patients to book. Early morning appointments were available with a GP or a nurse from 7am two mornings a week. The practice offered an online appointment booking service. The practice used a text message reminder service for patients and had used this to communicate with patients at short notice – for example if a GP was off sick.

The staff were proactive in calling patients into the practice for health checks. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. This gave the practice the opportunity to assess the risk of serious conditions on patients which attend. The practice also offered age appropriate screening tests including prostate and cholesterol testing.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available within the waiting areas.

Patients who received repeat medications were able to collect their prescription at a place of their choice. Patients said the repeat medication process was easy and worked well.

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 16 patients with a learning disability and had carried out annual health checks for just fewer than 26% of these patients. The others had declined the offer to attend but were sent further invites.

The practice had a very small number of non-English speaking patients. In most cases, family members would attend to translate at the patient's request. However, the practice also had the use of the telephone language line if needed. A longer appointment was offered to these patients to accommodate this service.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Vulnerable patients had been advised about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in both normal working hours and out-of-hours.

The practice promoted their chaperone service and reminded patients that if they did require assistance, they could ask. All clinical staff and senior reception staff had received chaperone training.

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). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medicine review.

Patients listed on the Dementia register had an alert on the clinical system to advise staff of their diagnosis. GP's were proactive in identifying patients with dementia and use recognised national assessments and referral processes. Families and friends were actively involved in their care.

Deprivation of liberty Safeguards (DOLS) were understood and all GP's had information to refer to for DOLS assessment procedures.

There was close liaison with the Psychiatry team and the practice facilitated the use of consulting rooms for the depression and anxiety team to use on a weekly basis.

Summary of findings

What people who use the service say

All of the 13 patients we spoke with were complimentary about the services they received at the practice. They told us the staff who worked there were very helpful and friendly. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system.

We reviewed seven CQC comment cards completed by patients prior to the inspection. All were

complimentary about the practice, staff who worked there and the quality of service and care provided.

None of those interviewed had any serious complaints regarding the practice. Patients praised the continuity of care and having had the same named GP in some cases throughout their life.

Patients told us they had a good rapport with their GP and felt no improvements were needed. They said GPs always phoned back when they said they would.

The latest National GP Patient Survey completed in 2014/15 showed patients were satisfied with the services offered at the practice.

The results of the GP Patient Survey score showed:

- 88% of respondents said the last GP they saw or spoke to was good at giving them enough time this was very slightly lower than the local (CCG) result of 91%.
- The proportion of respondents who gave a positive answer to how easy is was to get through to someone at the GP practice on the phone was 81% compared to the local (CCG) average of 84%.
- 63% of respondents said they usually waited 15 minutes or less after their appointment time to be seen compared to the local (CCG) average of 64%
- The percentage of patients rating their experience of making an appointment as good or very good was 95% compared to the local (CCG) average of 91%.

These results were based on 127 surveys returned. We discussed this result and the practice manager said the practice were fully aware of where improvement was needed. The practice were in the process of discussing how this could be improved and told us they were constantly striving to improve patient satisfaction.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a system for Nurse meetings to be more formal and minutes taken with actions agreed.
- Introduce a system to ensure policies are reviewed and updated.
- Give consideration to improving the disabled toilet facilities.

Hill Barton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Hill Barton Surgery

Hill Barton Surgery delivers primary care under a Primary Medical Services contract between themselves and NHS England. As part of the Devon Clinical Commissioning Group (CCG) they are responsible for a population of 3795 patients.

There is a team of three GP partners, two male and one female. The team were supported by a practice manager, two female practice nurses and a phlebotomist (staff who take blood). The clinical team were supported by additional reception, secretarial and administration staff.

The surgery is open between 830am and 6pm Monday, Thursday and Friday. Appointments are available between 8.30am and 5.30pm. Extended hours appointments are offered twice weekly on a Tuesday and Wednesday from 7am-8.30am.

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 GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the surgery is closed at the weekends.

There were no previous performance issues or concerns about this practice prior to our inspection.

Why we carried out this inspection

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

How we carried out this inspection

Before conducting our announced inspection of Hill Barton Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local NEW Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on 7th July 2015. We spoke with 13 patients, three GPs, two of the nursing team and members of the management, reception and

Detailed findings

administration team. We collected seven patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- 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 had a strong comprehensive safety system which used a range of information to identify risks and improve quality in relation to patient safety. Staff we spoke to were aware of their responsibility to raise concerns, and how to report incidents and near misses. Staff said there was an individual and collective responsibility to report and record matters of safety. We reviewed safety records, incident reports and minutes of meetings. These showed the practice had managed these consistently over time and so could demonstrate 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. We reviewed records of three significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were discussed as they happened and learning shared with all staff. These events were reviewed as necessary at the practice meetings. There was evidence from discussion with GPs and nurses that the practice had learned from events these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. For example on one occasion a patient was not informed to collect a repeat chest X-ray card after an abnormal result. Instructions were not made clear to the receptionists by a locum GP when asking for repeat x-ray. No harm came to the patient as this was discovered quickly. Learning was shared with the locum GP to prevent this reoccurring.

Staff told us that when they were involved in a complaint or incident they filled out an online form which was then sent to the practice manager. Staff explained it was discussed with them but they were also supported through the process and there was a no blame culture, as any event was seen as a way to improve safety and care. We saw evidence of action taken as a result and that the learning had been shared.

National patient safety alerts were disseminated by the business manager or GPs to practice staff by email or memo. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, precautions in place to help patients through the recent heatwave. These were then discussed at the clinical governance meetings and nursing meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were aware of their responsibilities and knew how to share information. They recorded safeguarding concerns and knew how to contact the relevant agencies, in working hours and out of normal hours. Contact details were easily accessible. The practice had appointed dedicated GPs as the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures. The procedure described the action to take in the event of a breach of these temperatures. The fridge temperature was checked and documented once a day and we saw appropriate temperature range had been maintained. The practice nurses were responsible for ensuring medicines were in stock and within their expiry dates. Vaccines were checked weekly for their expiry dates and rotated so that vaccines closest to their expiration date would be used first. Expired and unwanted medicines were disposed of in line with waste regulations. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and changes to patients' repeat medicines were managed. All prescriptions

were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a lead nurse nominated for infection prevention and control. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that an infection control audit had been undertaken in May 2015 and had identified that the waiting room had been dusty. This was immediately addressed with the cleaners and the area was thoroughly cleaned.

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, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff we spoke with were able to describe how they would use these in order to comply with the practice's infection control policies. There was also a policy for needle stick injuries. Hand hygiene techniques signage was displayed throughout the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had processes in place for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). Records confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. Sharp bins were available along with bins for the disposal of both ordinary and clinical waste. There was a contract in place for the removal of all household, clinical and sharps waste and we saw that waste was removed by an approved contractor.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly for patient use. Equipment maintenance logs and other records 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.

Staffing and recruitment

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 keep patients safe. They told us about the arrangements for planning and monitoring the number and mix of staff to meet patients' needs.

The practice had a recruitment policy in place. We looked at records relating to the most recently recruited clinical and administrative staff. We found appropriate pre-employment checks such as obtaining references and a criminal record check through the Disclosure and Barring Service (DBS) had been carried out. The practice had arrangements in place to assure them that the clinical staffs' professional registrations were up to date with the relevant professional bodies and that the required staff had medical indemnity insurance in place.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular 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.

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 and this was updated yearly. Emergency equipment appropriate for children and adults was available, including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment. Records confirmed it was checked regularly. Emergency medicines were available in various secure areas of the

Good

Are services safe?

practice. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use.

A business continuity plan was in place, which staff were aware of, 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, incapacity of staff, adverse weather, unplanned sickness and access to the building. The practice had carried out a fire risk assessment in October 2014. It included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff, this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need. National data showed that the practice was performing better than other practices in the CCG area for referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standard guidelines for the referral of patients with suspected cancers to ensure they were referred and seen within two weeks. Data showed 100% of patients had been seen by secondary care within two weeks of their original appointment.

The QOF (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures) provided evidence the practice were above local and national averages when responding to the needs of people with dementia, including those newly diagnosed with dementia. For those patients with dementia 91.2% had their care reviewed in a face-to-face review in the preceding 12 months.)

Data showed that child development checks were offered at intervals that were consistent with national guidelines and policy. To date 95% of children at the practice aged up to two years had received all their vaccinations and 94% were up to date with their preschool boosters.

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

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, an audit was undertaken for those patients using Proton pump inhibitors (PPIs). These reduce the production of acid by blocking the enzyme in the wall of the stomach that

produces acid. 51 patients were identified as using PPI. As a result of the audit 18% of the patients had their dose reduced and 25% had PPI stopped and were given lifestyle advice instead.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as fortnightly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. These patient names were listed at the practice so all staff could promptly recognise them and fast track any appointment of prescription request if necessary. Structured annual medicine reviews were also undertaken for people with long term conditions.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, medical emergencies, infection control and information governance. Staff also attended mandatory updates appropriate to their role, for example wound care. All GPs were up to date with their annual continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). The practice manager kept of record of appraisals and revalidation dates.

All staff had received an annual appraisal with a GP and the practice manager. During this meeting learning needs had been identified and action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example attendance at a study day about diabetes.

All the staff we spoke with told us they felt well supported by the GPs and nursing team as well as by the practice manager and each other. Patients told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with colleagues and other services

The practice had effective working arrangements with a range of other services such as the community nursing team, the local authority, the hospital consultants and a range of local and voluntary groups.

The practice was involved in various multidisciplinary meetings involving palliative care nurses, health visitors, social workers and district nurses to discuss vulnerable patients at risk, those with complex health needs, and how to reduce the number of patients needing hospital admission. The lead GP for safeguarding children attended monthly multidisciplinary meetings with the school nurse, health visitors and midwives to discuss patients on the child protection register and other vulnerable children. Minutes recorded the discussions about these issues. This enabled the practice to have a multidisciplinary approach which ensured each patient received the appropriate level of care.

The practice worked with other service providers to meet patients' needs and manage complex cases. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by

post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Regular informal meetings were held throughout the practice as well as formal staff meetings which were held six monthly. Nurse meetings were held on a weekly basis but these were not recorded so any actions required were not formally recognised. Information about risks and significant events were shared openly and all staff were able to contribute to discussions about how improvements could be made.

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets and posters about local services were available in the waiting area.

Consent to care and treatment

Staff referred to Gillick competency when assessing young people's ability to understand or consent to treatment, ensuring where necessary young people were able to give informed consent without parents' consent if they were under 16 years of age.

Staff were also able to describe how they assessed a patient's capacity to consent in-line with the Mental Capacity Act 2005, with guidance available in the Mental Capacity Act policy and consent policy.

A pathway was in place to enable appropriate referrals and support packages for patients at the end stages of life. Multi-disciplinary palliative care review meetings were held quarterly with other health and social care providers. Individual cases were discussed regularly between clinical staff to ensure patients and relatives needs were reviewed on a regular basis to meet each patient's physical and emotional needs. For patients nearing the end of life care plans were in place. For those patients nearing the end of life but not imminent, their wishes were recorded and reviewed by the lead GP, with changes communicated and shared with out of hour providers.?

Health promotion and prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check. New patient assessments were carried out by the practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice had a range of written information for patients in the waiting area. Information was available for patients to take away on a range of health related issues, local services and health promotion. A wide range of information was available on the practice website, with links to local and national support group's patients could access.

We were provided with details of how staff actively promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

We were told health promotion formed a key part of patients' annual reviews and health checks and included discussions and assessments of a patient's mental health. GPs were proactive in offering health checks where there was suspicion of early onset chronic disease.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice's performance for cervical smear uptake was 86.75% compared to the national average of 81.88%. The practice sent reminders for patients who did not attend for cervical smears and the practice audited this data. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from information from the national patient survey 2015. We spoke to 13 patients during our inspection and we received seven Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed a high level of satisfaction of patients with their GP practice. The results of the practice patient satisfaction survey showed that of the 127 responses received, 95 % of patients said that the practice was either 'fairly good or good which was higher than the local CCG average of 85%. We received seven comment cards and all of these stated that the service was 'good', 'very good' or 'excellent.'

The feedback we received from patients and carers showed that the staff and GPs knew the majority of their patients. Patients felt able to go to the practice without fear of stigmatisation or prejudice. The nursing team and the GPs were able to make longer appointments for those patients they knew may need longer because, for example, they had complex needs, were anxious or likely to become agitated if they felt they were being rushed. Patients we spoke with confirmed that they never felt rushed.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Patients said they felt the practice offered a good service and both clinical and administrative staff were helpful and caring. They said staff treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

The patients we spoke with told us their diagnosis and proposed treatment options were explained to them. They spoke of feeling reassured and safe in the care of the clinical team. Patients told us they felt involved in their care and treatment decisions. These views aligned with the findings of the most recent national GP patient survey results, which found 98% of respondents had confidence and trust in the last GP they saw or spoke to were good at involving them in decisions about their care, and 100% had confidence and trust in the last nurse they saw or spoke to.

Staff told us that translation services were available for patients who did not have English as a first language.

GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent. They told us they recorded best interest decisions, consulted carers with legal authority to make healthcare decisions and sought specialist advice if needed.

Patient/carer support to cope emotionally with care and treatment

We looked at seven CQC comments cards that had been completed and spoke to 13 patients. All comments were positive. Comments stated that they were pleased with the service, were treated with respect and said that the GPs went above and beyond what was required to make sure the care offered was appropriate. Patients said they always had enough time to discuss their problems and could make longer appointments if they needed them.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Information was available for carers to ensure they understood the various avenues of support available to them. The practice made referrals, with the patients consent, to local support groups such as Clyst Caring Friends, Neighbourhood Friends and Age UK for patients in need of support such as befriending or help with bathing. Appointments were available each month for carers to have a health check.

There was information on what to do in times of bereavement and patients we spoke with told us they were supported through all emotional circumstances. 97% of patients said they were given enough time during their appointment to talk through their concerns this compared higher than the local average of 94%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice management team involved the patient participation group (PPG) in the development of their patient survey and action plans in response to the feedback received.

Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. The GPs had individual lists, to promote continuity, and attached staff paid tribute to the focus on continuity of care within this practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. Temporary residents were welcomed.

The number of patients with a first language other than English was very low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The practice was a house that had been converted to become a GP practice. There was level access to the front door via a sloped pathway.

The seats in the waiting area were of different heights and size. There was variation for diversity in physical health and all had arms on them to aid sitting or rising. An audio loop was available for patients who were hard of hearing. There was an area for children to wait which had toys and books for them to use.

Inside the building the doors were difficult for a wheelchair user to use independently. However, staff said they would hold doors open should this be necessary. The toilet was not fitted with an alarm cord and the grab rail was not sufficient to assist a disabled person.

The reception desk was high but had a levered exit which enabled staff to come out and speak with patients if they were in a wheelchair.

The GP consultation rooms were on the first floor and nurse consultation rooms were on the ground floor. There was no passenger lift. Systems were in place to ensure that any patient that could not manage the stairs would be seen by the GP in a downstairs consultation room.

Access to the service

Appointments were available between 8.30am and 5.30pm Monday to Friday. Appointments made required between 8.30 and 9am were pre bookable. The rest of the mornings were bookable on the day. The practice offered online booking for appointments and telephone appointments one week in advance. Afternoon appointments were able to be booked up to two weeks in advance. The practice provided extended hours twice a week on a Tuesday and Wednesday between the hours of 7-8.30am. Nurse's appointments were available to pre book six weeks in advance.

Comprehensive information was available to patients about appointments in the practice itself and on the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

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

- 84% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.
- 83% described their experience of making an appointment as good compared to the CCG average of 83% and national average of 73%

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 81% said they could get through easily to the surgery by phone compared to the CCG average of 84% and national average of 73%.

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

For older people and people with long-term conditions home visits and longer appointments were available when needed.

Listening and learning from concerns and complaints

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

Information in the waiting room was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way.

The practice reviewed complaints to detect themes or trends but no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to support patients and to provide a high quality service delivered in a friendly and caring manner. Their vision was to endeavour to promote the health and wellbeing of patients and the GP team by practicing sustainable cost-effective evidence based medicine. The team culture and team behaviours reflected this.

The practice strategy was reviewed regularly by the partners. The GP partners worked well together to develop short and long term planning. The practice was aware of future NHS developments and any pressures which might affect the quality or range of service and was forward thinking in identifying ways to manage their impact. There was considered and constructive engagement with staff and a high level of staff satisfaction.

Governance arrangements

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

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework data in discussion at monthly team meetings, where action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. The practice monitored risks on a monthly basis to identify any areas that needed addressing. The practice held informal staff meetings where governance issues were discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example the infection control policy) which were in place to support staff. There were other policies that had not been reviewed annually with information that needed updating - for example for the management of Tuberculosis. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

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

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the GP patient survey which showed patients were satisfied with the care they received. For example 85% of the 127 patients that responded say the last GP they saw or spoke to was good at treating them with care and concern this was in line with the local CCG average of 85%.

The practice had a patient participation group (PPG) and had 18 members. The group met twice yearly and comprised of patients from all age groups. The national survey was carried out during the month of February 2015 and the information from this survey was discussed with the PPG at the meetings both in November 2014 and also

Are services well-led?

Good

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

on March 2015 with the PPG. One area of concern that was highlighted in the survey was the increased waiting times for patients in the waiting room. This was discussed and as a result changes were made to the times of the coffee breaks taken by the GPs. Following these changes it was found that waiting times had improved. The PPG said they will be would continue to monitor this.

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

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at one staff file and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they were well supported. The practice closed two afternoons per year in response to a CCG incentive. This was allocated training time for all staff. The time was used for group training sessions and information sharing.

The practice was not a GP training practice.