Holsworthy Doctors

Quality Report

Holsworthy Medical Centre
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Holsworthy Doctors was inspected on Monday 8 December 2014. This was a comprehensive inspection.

Holsworthy Doctors practice provides primary medical services to people living in a rural areas in North Devon covering approximately 250 square miles. Transport links within the area are limited. Holsworthy Doctors provides the highest level of area coverage within England. The area is mostly rural, with high percentage of agriculture and mid range deprivation. The practice provides primary medical services to a diverse population and supports patients living in eight adult social care homes in the area. Holsworthy community hospital is situated next to the practice and GPs have responsibility for 10 patient beds there. At the time of our inspection there were 10,700 patients registered at the service. The practice had a higher than national average number of patients of working age and older people, with fewer children and young people in the total practice population.

The practice has 7 full time GP partners; three male and four female GP partners. There are two Advanced Nurse Practitioners (female). The GPs are also supported by five practice nurses (female), four health care assistants (female) and two phlebotomists (female). The practice manager is also a partner, the registered manager with CQC and manages a large team of administrative staff. Holsworthy Doctors is a training practice, with two GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students. When we inspected there was GP and two second year registered doctors completing training placements at the practice.

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

The practice is rated as OUTSTANDING.

Our key findings were as follows:

- Patient satisfaction was higher than the national average, 92% compared with 86% in the 2014 GP survey. Fifty nine patients gave feedback at the

Summary of findings

inspection, in person (34) or in writing (25). All confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. The practice had a very good skill mix which included two advanced nurse practitioners (ANPs) and was able to see a broader range of patients than the practice nurses.
- The practice was purpose built and very well equipped to treat patients and meet their needs.

We saw several areas of outstanding practice including:

- The practice had a strong vision which had quality and safety as its top priority. A comprehensive business plan was in place, which was monitored and regularly reviewed. Progress with this and action plans were discussed with all staff and shared with PPG members. High standards were promoted and owned by all practice staff with evidence of team working across all roles and with external agencies. The practice held registers for every population group and used tools like the Kings Fund predictive model to rate risk so knew which patients could be at risk of unplanned admissions and ensured appropriate support was in place and well co-ordinated by the community team.
- The practice understood the needs of the patient list and the challenges of the rural location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. The practice hosted specialist clinics at the practice for procedures normally offered at the main hospital (29 miles away) such as diabetic retinal screening (held 3-4 times a year) regular hospital nurse specialist appointments for patients with complex diabetes and leg ulcer treatment. Access for working patients was facilitated through the availability of early morning appointments every day of the week and weekend clinics for flu vaccination were available throughout the Winter months. Patients were able to request repeat prescriptions and appointments online and sms texting was used for appointment reminders and blood test results. The patient list was managed in a way to avoid any barriers, for example patients who moved out of area were able to remain registered with the practice for continuity of care and treatment. Approximately 1482 patient appointments were delivered each month, which far exceeded the 802 expected for the list size. GPs carried out an average of four home visits each per day, travelling up to 15 miles on rural roads to reach patients in need. The practice also provided a rapid response service and emergency care to patients involved in road traffic accidents until the ambulance or air ambulance service could arrive.
- The practice was innovative in promoting collaborative working with other agencies to improve outcomes for patients. Significant challenges were overcome by the practice, which facilitated well co-ordinated safeguarding and management of patients with complex care needs. Social services were able to use the practice facilities for safeguarding strategy meetings, which had further enhanced working relationships. Patients, particularly women experiencing domestic violence were able to access discreet face to face social care support at the practice once a week. Holsworthy Doctors held monthly multidisciplinary meetings, which included hospital specialists from the palliative care team. The practice knew that it was difficult for patients needing palliative care support to travel to the local hospice approximately 25 miles away, so had facilitated the building of a satellite day hospice on land owned by the practice. Data showed 100% of all patients newly discharged from hospital following an emergency admission were visited within 24 hours by GPs from the practice to ensure they had appropriate care, treatment and support.
- The practice significantly improved access to support for patients living with long term conditions and their carers. For example, the Memory Matters programme run by the Alzheimer's society was hosted at the practice. This enabled carers and patients to attend who would otherwise be unable to travel the distance to Bideford or Barnstaple.

Patient participation was achieved in two ways, through a virtual PPG (50 patients) and face to face meetings with representatives from the Patient Participation Group (PPG). Their suggestions had developed into work streams to implement changes at the practice.

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.

The practice had a clear vision which had quality and safety as its top priority. Comprehensive systems and processes demonstrated that the practice was safe. The whole team were engaged in reviewing and improving safety and safeguarded patients. The practice had an open culture in which safety concerns raised by staff and people using the services were valued and seen as integral to improvement. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There was a proactive approach to anticipating and managing risks to people who use the services, which all of the staff understood and followed.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff teams and services were committed to working collaboratively. Patients who had complex needs were supported to receive co-ordinated care and there were innovative and efficient ways to deliver more joined up care to people using services.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. Holsworthy Doctors is a teaching practice. Data showed that the practice was performing highly when compared to neighbouring practices in the CCG leading to positive outcomes for patients registered there. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice specifically targeted at risk groups for health screening, support and treatment. Data also showed there was a low percentage of emergency admissions and attendance at A & E of patients registered at the practice. Medicines were reviewed for patients so that prescribing followed guidelines and was efficient and effective.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients rated the practice higher than others in national surveys and through the friends and family test for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. Staff were focussed on providing

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patient-centred care. The practice significantly improved access to support for patients living with long term conditions and their carers. For example, the Memory Matters programme run by the Alzheimer's society was hosted at the practice. This enabled carers and patients to attend who would otherwise be unable to travel the distance to Bideford or Barnstaple. Staff were 'Dementia Friends' so able to recognise and support patients who could be presenting with, but not yet diagnosed with dementia.

Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services

The practice understood the needs of the patient list, the challenges of the rural location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. Three GP partners and a nurse practitioner had undertaken specialist training to carry out micro suction for patients, which is a procedure usually done in hospitals to remove hardened ear wax. The practice hosted specialist clinics at the practice for procedures normally offered at the main hospital (29 miles away) such as diabetic retinal screening held 3-4 times a year, regular hospital nurse specialist appointments for patients with complex diabetes and leg ulcer treatment.

Access for working patients was facilitated through the availability of early morning appointments every day of the week and held weekend clinics for flu vaccination throughout the winter. Patients were able to request repeat prescriptions and appointments online and sms texting was used for appointment reminders and blood test results. The practice performance for delivering appointments far exceed what was expected. On average 1482 patient appointments were delivered each month, compared with 802 appointments expected for the list size. GPs carried out an average of four home visits each per day, travelling up to 15 miles on rural roads to reach patients in need.

The practice coverage was all rural covering 250 square miles (largest nationally). With the challenges of rural travel and sometimes hard to access areas, patient satisfaction was very high. The patient list was managed in a way to avoid any barriers, for example patients who moved out of area were able to remain registered with the practice for continuity of care and treatment.

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The practice provided a rapid response service and emergency care to patients involved in road traffic accidents until the ambulance or air ambulance service could arrive.

Are services well-led?

Outstanding 

The practice is rated outstanding for providing well led services.

The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed. This was discussed with all staff and shared with PPG members. High standards were promoted and owned by all practice staff with evidence of team working across all roles and with external agencies. Fifty nine patients we met or received written feedback from commented they felt safe and well looked after by the team at Holsworthy Doctors.

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The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as good for the care of older people.

All patients had a named GP and was able to see them or another GP of their choice. The practice held registers and used the Kings Fund predictive model to rate risk so knew which patients could be at risk of unplanned admissions. Conditions commonly found in older people were monitored closely. Nationally reported data showed that outcomes for patients were better than expected for conditions such as osteoporosis. 100% patients with this condition were being treated with bone sparing medicine to reduce the risk of fractures following falls.

Health promotion outcomes for older patients at risk were better than expected. For example, data for the annual influenza vaccination programme was at 92.6% in December 2014, which included older patients diagnosed with diabetes. This showed the practice had improved performance over the intelligent monitoring data we had access to prior to the inspection.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Holsworthy Doctors held monthly multidisciplinary meetings, which included hospital specialists from the palliative care team for example. They had leased land to a charity and a satellite hospice was being built next to the practice to provide easier access for patients in need of support and end of life care. Patients at risk of unplanned admissions due the complexity of their conditions were closely monitored at a monthly multidisciplinary meeting with the complex care team and community matron.

The practice was innovative in promoting collaborative working with other agencies to improve outcomes for vulnerable older patients. Significant challenges were overcome by the practice, which facilitated well co-ordinated safeguarding and management of patients with complex care needs. Social services were able to use the practice facilities for safeguarding strategy meetings, which had further enhanced working relationships. It was responsive to the needs of older people, and offered home visits and rapid access appointments for and carried out reviews with patients in their own homes if they did not attend the practice. Data showed 100% patients newly discharged from hospital following an emergency admission were contacted within 24 hours to ensure they had appropriate support and treatment.

Summary of findings

The practice supported patients living in eight adult social care homes in the area. Each care home had a named GP as a link to the practice. Reviews of patients took place in a planned way and included advanced care planning with patients and/or their carers. Care plans were shared with the Out of Hours service to promote continuity of care for patients when the practice was closed.

People with long term conditions

Outstanding 

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Summary of findings

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Families, children and young people

Outstanding ☆

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations with results ranging

between 93-100%. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses

The practice was innovative in promoting collaborative working with other agencies to improve outcomes for patients. Significant challenges were overcome by the practice, which facilitated well co-ordinated safeguarding of vulnerable children, young people and adults. Social services were able to use the practice facilities for safeguarding strategy meetings, which had further enhanced working relationships. Patients, particularly women experiencing domestic violence were able to access discreet face to face social care support at the practice once a week.

The practice had systems in place to meet the needs of children and young people. Appointments outside of school hours were available after 3pm every day for young people and children. Appointments could be booked right up until 3pm should parents need their child or young person to be seen by a GP. The practice worked closely with health visitors and school nurses to support patients.

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Data showed the practice had achieved very high rates of cervical screening for female patients. The practice had a much higher uptake of 90.6% female patients having cervical screening in the last five years when compared to national and local data (60% and 68%).

Working age people (including those recently retired and students)

Outstanding ☆

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

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. Extended hours appointments were available every day, providing early appointments from 7.30 am to avoid disruption for working patients. Patients could choose to see their named GP where available, a nurse or healthcare assistant for these appointments. The practice offered flexible, 10, 15 or 20 minute or longer appointments for patients if needed. The practice had an online appointment booking system and appointments were available before the main surgery times twice a week. Telephone appointments were available and the practice remained open to patients over the lunchtime period between appointment sessions. Other online services such as ordering repeat prescriptions were available to patients on the practice website. SMS text messaging was used for patients wishing to use this service for reminders about appointments and blood results.

Health checks for patients aged 40-75 years old were promoted in information posted on the website and throughout the practice and in the newsletter. Smoking cessation, weight loss advice and alcohol screening and interventions were provided.

The practice was responsive to patient needs and had obtained a centrifuge, which allowed blood tests to be drawn all day. Samples were normally collected and taken to the main hospital in Barnstaple at 11 am. Working patients were therefore able to have later appointments after work to have blood samples taken for testing.

Patients returning to work following a period of illness were supported by providing appropriate documentation required. Patients were signposted to other support helping them to build their confidence to return to work.

People whose circumstances may make them vulnerable

Outstanding ☆

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

Summary of findings

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out 100% annual health checks for people with a learning disability and had carried out further investigations and treatment where necessary.. It offered longer appointments for people with a learning disability. Some of the patients with learning disabilities had complex needs, living in nearby adult social care homes. The practice had worked closely with the learning disability team to support these patients and help them transition to their new home when they moved into the area. GPs had developed trusting rapports with people so that any anxieties they might be experiencing could be reduced so their health was appropriately monitored.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients 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 normal working hours and out of hours.

The practice was innovative in promoting collaborative working with other agencies to improve outcomes for patients. Social services were able to use the practice facilities for safeguarding strategy meetings, which had further enhanced working relationships. Patients, particularly women experiencing domestic violence were able to access discreet face to face social care support at the practice once a week. The locality had a violent patient scheme to which the practice could refer patients. However, to meet individual needs and reduce the impact for patients the practice had facilitated this scheme being run at the practice. Patients were still seen safely at the practice, supported by external mental health workers and security staff at quieter times of the day.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

The practice held a register of patients experiencing poor mental health, including those diagnosed with dementia. Prompts within the patient record system highlighted when they had a carer and any potential risks so that GPs focussed on the support patients needed. Data showed that the practice engaged well with people experiencing poor mental health. For example, health screening performance for blood pressure, cholesterol, blood glucose and

alcohol consumption ranged between 86.6 % and 97.8% (up to December 2014). The practice had completed cervical smears for 100% of female patients with complex mental health needs. The practice had completed care plans for 78.7% patients with complex mental health needs, which included identification of potential risks, actions to reduce these and carer support.

The practice facilitated patients access to counselling from the Depression and Anxiety Service (DAS) nearer to home by making a room available every week for these appointments to take place. Patients were able to avoid having to travel to Barnstaple (28 miles away).

The practice regularly worked with multi-disciplinary teams in the case management of people diagnosed with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs. Longer appointments at quieter times of the day were offered. The team worked closely with the community mental health team based in Holsworthy and accessed support when patients were in crisis.

The practice significantly improved access to support for patients living with long term conditions and their carers. For example, the Memory Matters programme run by the Alzheimer's society was hosted at the practice. This enabled carers and patients to attend who would otherwise be unable to travel the distance to Bideford or Barnstaple. They knew how to appropriately support patients in this situation and signpost them and their carers to the local memory clinic for assessment.

Summary of findings

What people who use the service say

We looked at patient feedback from the national GP survey for 2014, when 266 patients provided responses. High levels of satisfaction were seen in the survey responses. Access to the practice was very good and patients could see a GP quickly. 93% of patients reported that their overall experience of their GP surgery was fairly good or very good. All of the feedback was positive.

Fifty nine patient gave feedback at the inspection, in person (34) or in writing (25). All confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Many of the patients we met said their care was exceptional and outstanding and they had been listened to. They told us that they found the reception staff to be helpful and caring. The practice was said to be very efficient and well run. Patients told us that appointments were easy to access and when urgent care was needed it was immediate and reassuring.

Patients said they appreciated having a range of appointment options, which included being able to be seen and treated by nurses with specialist qualifications. The practice had two advanced nurse practitioners who provided treatment for minor injuries and management for long term conditions.

The practice had a virtual patient participation group (PPG) of more than 50 patients. Face to face meetings were held with 8-10 patients from a cross section of the practice population. These were three monthly and attendees were patient representatives from all the surrounding villages covered by the practice. We spoke with the chair person and three other members of this group. The PPG felt that the relationship with the partners was good and they worked closely with them and had an action plan which was updated at each meeting to review progress with suggestions made. For example, appointment waiting times had been reviewed and there was improved communication with patients when there were delays. The practice had also introduced a buddy system for nurses for example, so that if a nurse appointment was running late the patient would be immediately offered an appointment to see the buddy. This had the effect of reduced appointment waiting time for patients.

Outstanding practice

- The practice had a strong vision which had quality and safety as its top priority. A comprehensive business plan was in place, which was monitored and regularly reviewed. Progress with this and action plans were discussed with all staff and shared with PPG members. High standards were promoted and owned by all practice staff with evidence of team working across all roles and with external agencies. The practice held registers for every population group and used tools like the Kings Fund predictive model to rate risk so knew which patients could be at risk of unplanned admissions and ensured appropriate support was in place and well co-ordinated by the community team.
- The practice understood the needs of the patient list and the challenges of the rural location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. Three GP partners and a nurse practitioner had undertaken specialist training to carry out micro suction for patients, which is a procedure usually done in hospitals to remove hardened ear wax. The practice hosted specialist clinics at the practice for procedures normally offered at the main hospital (29 miles away) such as diabetic retinal screening (held 3-4 times a year) regular hospital nurse specialist appointments for patients with complex diabetes and leg ulcer treatment. Access for working patients was facilitated through the availability of early morning appointments every day of the week and weekend clinics for flu vaccination were available throughout the Winter months. Patients were able to request repeat prescriptions and appointments online and sms texting was used for appointment reminders and blood test results. The patient list was managed in a

way to avoid any barriers, for example patients who moved out of area were able to remain registered with the practice for continuity of care and treatment. Approximately 1482 patient appointments were delivered each month, which far exceeded the 802 expected for the list size. GPs carried out an average of four home visits each per day, travelling up to 15 miles on rural roads to reach patients in need. The practice also provided a rapid response service and emergency care to patients involved in road traffic accidents until the ambulance or air ambulance service could arrive.

- The practice was innovative in promoting collaborative working with other agencies to improve outcomes for patients. Significant challenges were overcome by the practice, which facilitated well co-ordinated safeguarding and management of patients with complex care needs. Social services were able to use the practice facilities for safeguarding strategy meetings, which had further enhanced working relationships. Patients, particularly women experiencing domestic violence were able to access discreet face to face social care support at the practice once a week. Holsworthy Doctors held monthly multidisciplinary meetings, which included hospital specialists from the palliative care team. The practice knew that it was difficult for patients needing palliative care support to travel to the local hospice approximately 25 miles away, so had facilitated the building of a satellite day hospice on land owned by the practice. Data showed 100% of all patients newly discharged from hospital following an emergency admission were visited within 24 hours by GPs from the practice to ensure they had appropriate care, treatment and support.
- The practice significantly improved access to support for patients living with long term conditions and their carers. For example, the Memory Matters programme run by the Alzheimer's society was hosted at the practice. This enabled carers and patients to attend who would otherwise be unable to travel the distance to Bideford or Barnstaple.

Holsworthy Doctors

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a variety of specialists: a practice manager, practice nurse and an expert by experience.

Background to Holsworthy Doctors

Holsworthy Doctors practice provides primary medical services to people living in a rural areas in North Devon covering approximately 250 square miles. Transport links within the area are limited. Holsworthy Doctors provides the highest level of area coverage within England. The area is mostly rural, with high percentage of agriculture and mid range deprivation. The practice provides primary medical services to a diverse population and supports patients living in eight adult social care homes in the area. Holsworthy community hospital is situated next to the practice and GPs have responsibility and admission rights for 10 patient beds there. At the time of our inspection there were 16,700 patients registered at the practice. The practice had a higher than national average number of patients of working age and older people, with fewer children and young people in the total practice population.

The practice is contracted through the NHS to provide general medical and local enhanced services. Outcomes for patients are monitored through the Quality and Outcomes Framework (QOF).

The practice has 7 full time GP partners; three male and four female. There are two Advanced Nurse Practitioners (female). The GPs are also supported by five practice nurses (female), four health care assistants (female) and two phlebotomists (female). The practice manager is also a partner, the registered manager with CQC and manages a large team of administrative staff. Holsworthy Doctors is a training practice, with two GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students. When we inspected there was GP and two second year registered doctors completing training placements at the practice.

Holsworthy Doctors is open from 8am-6pm Monday and Friday. Extended hours were in place every day for patients that find it difficult to visit the GP during the day. Appointments were available from 7.30 am each day for working age patients. After 6pm every evening and at weekends when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. The out of hours arrangements are in keeping with all GP practices across North, East and West Devon Clinical Commissioning Group.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the 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.

Prior to the inspection, intelligent monitoring showed that there was an increased risk regarding the percentage of patients aged 65 and older who had received a seasonal flu

vaccination for the winter period up to the end of February 2013. We followed this up at the inspection to establish what action the practice had taken to address this and whether this had improved.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 8 December 2014.

During our visit we spoke with a total of 21 staff: 7 GP partners, the practice manager partner, 2 advanced nurse practitioners, 3 practice nurses, 3 health care assistants and 5 administrative and reception staff. We also spoke with 34 patients who used the practice. We observed how patients were being cared for and reviewed 25 comment cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. All of the staff we spoke with knew how to raise concerns including reporting incidents and near misses. GPs told us these were discussed at their daily coffee meetings Monthly quality assurance meetings were held, we saw the minutes for October and November 2014. Standing items about health and safety, significant events, complaints, risk assessments and infection control matters had been discussed. All of the staff we met confirmed receipt of these minutes and were able to describe issues highlighted in them.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Through one to one and written feedback, patients told us they felt safe when attending the practice.

GP partners told us that when they received MHRA alerts (medical alerts about medicines safety) these were discussed in several ways. GPs and nursing staff had a morning coffee meeting to discuss these and any patient issues that had arisen. Practice meetings disseminated the information to other staff and showed actions taken and we saw two examples of these. GPs told us they searched their patient records to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. Medical alert information was shared electronically to clinical staff in the practice and published on the practice intranet.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw the records of 16 significant events that had occurred in the previous 12 months up to November 2014. Team meeting minutes showed significant events were discussed to identify concerns and share learning with the staff. This included temporary staff working at the practice such as medical students, GPs in training and locum GPs. The significant events log was discussed and trends highlighted where appropriate. The practice also had two forums for reviewing this information a quality performance meeting and partners meeting. Both of these meetings were was held each month. We looked at minutes of the last quality performance meeting in November 2014, which showed the practice was strongly committed to learning from patient experience and improving the outcomes for them. The practice manager who was also a partner, readily produced up to date data at the inspection showing the total number of face to face consultations that had taken place, all written feedback from patients, including complaints. This showed there were strong systems in place to monitor risks at the practice.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked incidents recorded for 2014 and saw records were completed in a comprehensive and timely manner and showed action had been taken. For example, during routine checks a small number of vaccines were found to be frozen. All of the vaccines were removed from use, destroyed and replaced. The practice had investigated why this had happened and made alterations to the equipment and stock checks as a result to promote patient safety. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated electronically via the practice intranet to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. 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 and knew how to share information, correctly document

safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible in every treatment room and staff areas in the practice.

There were GP leads 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. For example, they had completed level 3 children safeguarding training. All of the staff had completed basic (level 1) safeguarding training for adults and children. All of the nursing staff had also completed intermediate level 2 safeguarding training for adults and children. All other GPs at the practice had completed level 3 safeguarding training, which is a requirement for revalidation of their fitness to practice. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and adults at risk. We looked at the virtual ward record for September 2014. This showed the practice closely monitored patients and carers needs in conjunction with key health and social care professionals supporting them.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Patients could choose to be seen by either a female or male GP(A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice staff were mindful that the ratio of female to male staff was higher, for example prompting male patients about whether they would prefer to see male staff. All nursing staff, including health care assistants, had been trained to be a chaperone. The practice had assessed risks and records showed that disclosure and barring service (DBS) checks had been carried out for all of these staff.

Medicines Management

The GPs were responsible for prescribing medicines at the practice. Two nurses also held nurse practitioner qualifications and had done additional training to enable them to prescribe medicines. The control of repeat prescriptions was managed well. Prescription scripts were kept secure when not in use. Patients were not issued any medicines until the prescription had been authorised by a GP. The practice supported patients living in deprived circumstances, a small number of older people found it difficult to attend the practice to be reviewed or chose not to do so. The practice had set up a home visit system so that health and prescription reviews could be done with patients at their own homes instead. This was an exceptional service which promoted patient safety with vulnerable and hard to reach groups.

Patients were satisfied with the repeat prescription processes and had direct access to their personal records on request. They were notified of health checks needed before medicines were issued. Patients explained they could do this in person, by phone, sms text messaging or via the on-line request facility for repeat prescriptions. Information about these systems were in the practice leaflet, posters around the waiting room and on the website.

Arrangements were in place for the safe management of medicines. Practice nurses were responsible for the management of medicines within the practice and there were up-to-date medicines management policies. Medicines were kept secure in a locked cupboards. The arrangements for storing the keys to this cupboards were secure. Controlled drugs were stored in the locked cupboard and only authorised staff had access to these. Expiry date checks were undertaken regularly and recorded.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Training records showed that nurses had received appropriate training to administer vaccines. Fridge temperatures were checked daily showing that medicines were stored at the correct temperatures.

Patient participation group members told us they had helped the team with the flu vaccination campaign, directing patients into the venue and provided teas and coffees whilst they waited. Information about who was eligible for flu vaccination was clearly displayed in the waiting room, newsletter and on the practice website.

Good

Are services safe?

Cleanliness & Infection Control

Thirty four patients we spoke with told us the practice was always clean and tidy and this was confirmed by our observations. Twenty five patient comment cards fed back that there were no concerns about cleanliness of the practice.

The practice had a lead nurse 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 regular updates. Nursing staff said they had carried out comprehensive audits of the practice in 2014. We saw a copy of the an audit completed in October 2014. Minutes of the quality assurance meeting showed there was a standing item to discuss infection control matters. In November 2014, the practice was reviewing the standard list of cleaning products used and a control of substances hazardous to health assessment was carried out and disseminated to staff using these products.

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, five nurses told us they cleaned equipment used to test patients blood pressure and lung capacity after every patient. Treatment rooms were cleaned at the beginning and end of every session. Paper covers were used on equipment and changed after every patient.

Policies in place covered areas such as personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use. The practice had a needle stick injury policy, which linked with occupational support for staff in the event of an injury. A needle stick injury had been reported under the SEA process and investigated. Staff told us they had been made aware of the latest guidance about needles and were using safer equipment outlined in the procedures.

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 policy for handling samples for investigation clearly set out how these should be handled to reduce the risk to staff. We saw staff followed this procedure, for example when patients brought urine samples in for testing we saw staff using gloves and had a receptacle for the specimens in reception.

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). The practice produced records showing that a risk assessment had been carried out by an external contractor. Action had been taken following the assessment to reduce the risk of infection to staff and patients.

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 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

Records showed that there was a low turnover of staff at the practice. We looked at four 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). One staff file did not contain photo identification, which the practice manager said they would obtain. The practice manager held a register showing when satisfactory checks had been completed, which showed that the performers list had been checked when GPs and locums were recruited. This also included the date when GPs and nurses had completed or were due to complete revalidation of their fitness to practice. Copies of medical defence insurance were seen in files, which were valid for the current year. 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 nurses or healthcare assistants had this additional duty and a DBS had been obtained for all of them.

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, two nurses 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. Nurses had completed several advanced nursing diplomas. These included the respiratory care of patients, diabetes management, contraception, sexual health promotion and mental health issues. Two out of seven of the nurses working at the practice held qualifications allowing them to prescribe medicines. This included ongoing assessment of their competency to prescribe treatment for patients. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. The practice was innovative in the way administrative arrangements had been set up to promote patient safety and follow up of results. Each GP had their own list of patients and a named secretary to handle correspondence about pathology results and hospital referrals. Patients knew the names of the secretary dealing with this flow of information and were able to liaise directly with that person to follow up when letters were sent and received. For example, a patient explained that they had been informed about problems with booking an urgent appointment for them to see a specialist. They told us they felt reassured that this member of staff had followed this up, kept them aware of developments and had obtained the appointment for them.

Staff told us there were always enough staff to maintain the smooth running of the practice. Arrangements to respond to same day requests for appointments for patients and managing waiting times had been reviewed. A buddy system had been put in place, which allowed the nursing team to respond more rapidly when patients presented in urgent need or were particularly unwell. Fifty nine patients gave feedback in person or in writing that there were always enough staff on duty to meet there needs. The practice manager showed us records demonstrating that actual staffing levels and skill mix were in line with planned staffing requirements. Each day the GP on rota responded to urgent needs from patients. All of the GPs carried out at least four home visits where necessary between patient sessions to see people who could not attend or carry out reviews. This could mean travelling up to 15 miles to reach patients on rural roads. This was exceptional and data showed that 100% of all patients newly discharged from hospital following an emergency admission were visited within 24 hours.

Nursing staff had a broad range of responsibilities and tended to see patients with more complex needs. Some of the nursing responsibilities were delegated to a healthcare assistant and included taking blood pressures and blood for testing. Training records and discussion with these staff verified that they had undertaken further training and had been assessed as competent before carrying these out. For example, a healthcare assistant confirmed they had completed a blood taking course at the hospital phlebotomy department. They said they felt well supported by the nurses and shadowed them until they felt confident and were assessed as competent to take blood from patients for testing.

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 daily, weekly, monthly and annual 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. These were discussed in several forums, for example quality assurance meetings were held monthly and minutes had a standing item which covered risks and health and safety matters. Minutes from the November 2014 meeting showed there was a potential slip risk to patients and other visitors to the building due to moss on a path outside. Actions were highlighted with a named member of staff responsible for following this up and we found the actions had been completed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Records showed that all of the reception team had been trained to recognise potential emergencies. Staff told us there was a rapid response system in place to alert GPs if they were concerned about a patient. For example, an extremely ill child with diabetes was brought to the practice by a parent.

Good

Are services safe?

Staff immediately recognised the severity of the situation and called for immediate support from a GP who examined the child and diagnosed they were having a diabetic crisis, which was potentially life threatening. The patient was cannulated and given IV fluids whilst waiting for emergency services to arrive. The child was successfully treated at the hospital and recovered.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and had an annual update 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). All staff asked knew the location of this equipment and records confirmed these were checked weekly and resealed afterward to show everything was in date.

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 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. The lead practice nurse 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. The practice was innovative in that data from the last census had been used to identify potential gaps in services and forward plan to address these. Risks were identified in the plan and rated with mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The practice held a map denoting where vulnerable patients lived, which was constantly under review so the team knew response times, distance and most direct routes to reach each patient.

Fire safety policies and procedures were in place. Information about checks and guidance for staff was in one place and held in reception. A fire risk assessment had been undertaken. Records showed staff were up to date with fire training and regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Care pathways were used by staff to clearly outline the rationale for their approaches to treatment. The practice had a lead GP partner responsible for quality assurance, which included reviewing and disseminating NICE guidelines. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GP and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice held registers for every population group and used the Kings Fund predictive model to rate risk so knew which patients could be at risk of unplanned admissions. Conditions commonly found in older people were monitored closely and the practice shared the latest statistics about this for the current year. Nationally reported data showed that outcomes for patients were better than expected for conditions such as osteoporosis. For example, 100% patients with this condition were being treated with bone sparing medicine to reduce the risk of fractures following falls. Diagnosis rates were high for patients with chronic kidney disease, 100% patients had been diagnosed as needing treatment for hypertension and were receiving it.

GP partners told us there was a joint leadership approach with the two advanced nurse practitioners for management of diabetes, heart disease and asthma for patients. This allowed the practice to focus on specific conditions aligned with the patient population needs. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support and used the morning coffee meeting each day to discuss complex patient issues.

Data from the local CCG of the practice's performance for antibiotic prescribing was comparable to similar practices. The practice had also completed a review of case notes for patients with dementia. This showed some treatments were reviewed and timings for future reviews were planned and person centred. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within a week by their GP according to need.

National data showed that the practice was in line or better regarding referral rates to secondary and other community care services for all conditions. The GP partner we spoke with confirmed that the practice used national standards for the referral. For example, patients with suspected cancers had been referred and seen within two weeks. The practice manager shared the latest performance data, which showed that 91.6% patients with cancer had been reviewed within six months of being diagnosed. The practice had an innovative system in place to closely monitor referrals made and follow up with secondary services if no outcome letter was received. Each GP had a link secretary who was responsible for managing this process, liaising with secondary services and the patient.

Discrimination was avoided when making care and treatment decisions. Interviews with all the staff 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. All of the staff understood the diversity of the patient group registered at the practice. A parent with two children who had learning disabilities told us the team were very good at listening. They said treatment options were explained at the right level for their children so they felt involved in making decisions about their care and treatment.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager partner to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last two years. Two of these were

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Are services effective?

(for example, treatment is effective)

completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The GP and nurses 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, a GP had audited their performance regarding the fitting of interuterine devices for female patients. Two cycles of audit had been completed and at the second showed recorded consent had improved in the second cycle. The audits also looked at recording of whether a chaperone was present and whether the patient was pregnant and whether there had been consistent recording of detailed assessment, technique and post insertion examination. The second audit showed the latter had improved in all cases. Forty nine patient records had been reviewed and none of the patients had experienced risks associated with this procedure, which included perforation, infection, explusion or failure of the device.

Data showed that there could be an increased risk regarding the percentage of patients aged 65 and older who had received a seasonal flu vaccination for the winter period but were not in at risk group and therefore did not have a long term condition. Based on performance of 62% up to the end of February 2013, the practice performance was below the national average of 74%. We followed this up at the inspection to establish what action the practice had taken to address this and whether this had improved. Staff explained that this group of patients was a target area and the practice had used their website, newsletter, local newspaper and community networks with the help of PPG members to raise awareness for patients. The practice newsletter for June 2014 demonstrated that appointments for flu vaccination were being booked from that point onwards. Flu vaccination clinics were being held on Saturdays. They told us this would always be a challenge to engage the farming community and had considered running a flu vaccination clinic at the local weekly livestock market.

The practice widely used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any other QOF (or other national) clinical targets. The practice manager closely monitored performance every month and shared with us the current performance levels at the inspection. For example, up to December 2014, 86.7% patients with diabetes had experienced an annual review of their health, which included blood screening and foot checks. The practice had recall systems for patients, which included letter, phone and sms text messaging to remind them to book a review. Nursing staff told us they were also prompting patients who had not responded to these reminders.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff demonstrated they knew the key areas of need amongst the patient group registered at the practice. For example, some patients presented with complex mental health needs including addictions. The staff closely monitored the health and well being of patients and used nationally recognised tools to assess addictive behaviour, signpost or refer patients on to specialist services. The GPs shared care for patients undergoing community detoxification for substance misuse and worked closely with other third sector agencies such as RISE to deliver this safely in the community for patients.

A protocol for repeat prescribing which was in line with national guidance was in place. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Thirty four patients we spoke with confirmed this took place. Routine health checks were monitored and 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 looked at an audit which looked at treatments prescribed for patients with a diagnosis of dementia. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. The timings of reviews were planned to be totally patient centred.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Each month patients were discussed and records showed that the practice used

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Are services effective?

(for example, treatment is effective)

a traffic light system to highlight levels of risk. There was a clearly co-ordinated plan for each patient on the risk register, which was reviewed every month with the multidisciplinary team supporting the patients. The practice held a coffee meeting every morning for GPs and the nursing team, to which other members of the multidisciplinary team working the community were invited to attend if they had any concerns about patients. This resulted in GPs deciding when a rapid response appointment might be required to review a patient at risk.

Effective staffing

Holsworthy Doctors provided training placements for GPs and medical students. Two GP partners were approved trainers and worked in conjunction with the local medical deanery to deliver the training programmes. Vocational training placements at the practice had been subject to regular scrutiny by the medical deanery.

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. We noted a good skill mix among the doctors, all having specialist interests in areas such as obstetrics and gynaecology, dermatology, respiratory, gastroenterology and minor surgery. For example, one of the GP partners at the practice also held additional diplomas in sexual and reproductive medicine. The practice had a register for all staff, which showed GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England. The practice monitored registration information held by the Nurses, Midwives Council to ensure nurses were fit to practice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. On the day of the inspection, there were no GPs or students in training working so we were unable to speak with them.

There were two advanced nurse practitioners holding diplomas in asthma and chronic obstructive airways disease management. They were qualified prescribers which meant that they could diagnose and prescribe some types of medicines for patients as well as treating minor illnesses. Training records, audit and policies showed this was done safely. A named administrator managed the list of patients with long term conditions and nurses told us they were updated regularly about this. For example, the extended nursing role and on-going training meant that the nurses had been assessed as being competent to see patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease and help them manage their health care. A multidisciplinary approach was taken regarding patients with complex needs, which involved joint discussions with the GP partners, other GPs and specialists.

The practice had policies and procedures in place to manage poor performance if necessary.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and in particular those with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Every GP had a named secretary who procesess these documents and results to ensure GPs actioned these every day. When GPs were on leave there was a buddy system in place for correspondence and results to be reviewed and actions taken. All staff we spoke with understood their roles and felt the system in place worked well. Significant events records demonstrated there were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an

enhanced level of service provision above what is normally required under the core GP contract. We saw that the policy for actioning hospital communications was working well in this respect. Multidisciplinary staff working in the community were invited to join the morning coffee meeting held between GPs and nursing staff at which patients newly discharged from hospital were discussed and actions agreed where necessary. The practice had responsibility for 10 beds at Holsworthy hospital, so patients were frequently transferred there from the main hospital to facilitate their discharge home. GPs from the practice reviewed patients daily at the hospital and within 24 hours of discharge home to ensure they had the appropriate support, care and treatment. Data showed the practice had low rates of unplanned admissions for patients.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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. Electronic systems were also in place for making referrals through the Devon single point of access scheme. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic summary care record and planned to have this fully operational by 2015. Summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. Information about the shared care record system was available on the practice website and in newsletters.

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.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, the practice supported older patients living in adult social care home and where appropriate the lead GP had met with patients and their advocates to develop a treatment escalation plan for each person. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice supported 40 patients with learning disabilities, some of whom had complex needs and lived in adult social care homes. There was a named GP linked with each home so that relationships could be developed, helping to reduce any anxiety patients might have. Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. A parent with two children who had learning disabilities told us the team were very good at listening. They said treatment options were explained at the right level for their children so they felt involved in making decisions about their care and treatment.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We

were shown an audit that confirmed the consent process for minor surgery had being followed in 100% of cases. Nursing staff described the consent process they followed with patients, which was documented for all consultations. Monthly spot checks of randomly selected patient records had taken place to review whether consent for example had been recorded. These were across the whole clinical team.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint. Some patients registered at the practice lived at eight adult social care homes and the team at Holsworthy Doctors also understood the procedures for reporting suspected unlawful restraint to the local safeguarding board.

Health promotion and prevention

The practice had strong links with the clinical commissioning group. The Joint Strategic Needs Assessment (JSNA) pulls together information about the health and social care needs of the local area. The practice had used this information to help focus health promotion activity. The practice also had a comprehensive five year business plan, which highlighted that the projected population increase for the practice up to 2017 would be around 7.7% and were planning the services around this. For example, this included the development of an in house health trainer to deliver health education and promotion programmes to patients.

It was practice policy to offer a health check with the health care assistants or practice nurses to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture at the practice for all clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The team identified that there was a high proportion of patients potentially at risk of alcohol abuse or drugs misuse due to high deprivation levels. Opportunistic alcohol screening and advice was being given to patients. The practice worked closely with third sector providers specialising in drug and alcohol addiction support and sharing the care of these patients whilst they detoxed and changed their lifestyles.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed there was a good uptake of patients in this age group who had had health checks. A GP explained that patients were followed up immediately if they had risk factors for disease identified at the health check and scheduled further investigations. For example, a patient with symptoms indicating that they had chronic renal failure was promptly seen and had begun treatment.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, data for 2014 showed that 100% of obese patients had a recorded BMI rate. Patients who were at risk of developing long term health conditions as a result of being obese had recorded advice and support offered to lose weight.

Child surveillance health surveillance at the practice was consistently above the national average, with 100% of children on the practice list having recorded developmental checks carried out. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was consistently higher than the national average. For example, immunisation rates for children up to 12 months of age were at 100%. For children between 12 months and 24 months of age, the immunisation rates ranged between 93.1% to 96.1%. For children 24 months and 5 years immunisation rates ranged between 97.1 to 100%. Staff described how this also linked to patient records, which showed when children and siblings within the same family were at risk of suspected or actual abuse. The practice had a clear policy for following up non-attenders by a named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The most recent data available for the practice on patient satisfaction showed very high levels of satisfaction. This included information from the national patient survey 2014 when 266 patients responded. High levels of satisfaction were seen in the survey responses. Access to the practice was very good and patients could see a GP quickly. 93% of patients reported that their overall experience of their GP surgery was fairly good or very good. All of the feedback was positive. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 99.2% patients commented that nurses treated them with care and compassion when compared with 90.5% nationally.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and put their needs first. Staff were described as being efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with 34 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The practice had clear policies and procedures in place around confidentiality, which were being followed Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. The reception desk was situated away from the waiting room so provided more privacy for patients discussing issues with the staff there. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations and we did not hear any conversations taking place in these rooms.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Reception staff demonstrated they understood how to diffuse potentially difficult situations and confirmed they had received training on this. We saw staff put patients at ease which had a positive effect on engagement with patients that had complex mental health needs. The locality had a violent patient scheme to which the practice could refer patients. However, to meet individual needs and reduce impact for patients the practice had facilitated this scheme being run at the practice. Patients were able to still be seen safely at the practice, supported by external mental health workers and security staff at quieter times of the day.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 96.1% of practice respondents said the GP involved them in care decisions.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

In a practice survey of 266 patients carried out in 2014, patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95.8% of patients considered they were treated with care and concerned during their consultation with the clinical team. The 34 patients we spoke with on the day of our inspection and 25 comment cards we received were also consistent with this survey information. For example, comments highlighted that all of the staff were compassionate, caring and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number

Good

Are services caring?

of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice had links with a carer support worker. Appointments were available each month for carers to have a health check. The practice ran a carers group, which provided access to advice and information and was next due in January 2015.

The practice significantly improved access to support for patients living with long term conditions and their carers. For example, the Memory Matters programme run by the Alzheimer's society was hosted at the practice. This enabled carers and patients to attend who would otherwise be unable to travel the distance to Bideford or Barnstaple.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, practice staff told us that there was a high incidence of patients registered at the practice with substance misuse problems who wished to change their lifestyle. The practice worked closely with third sector agencies to safely manage the detoxification process for suitable patients living in the community. This facilitated continuity of care for patients in such situations.

The NHS England Area Team and North East and West Devon Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the virtual patient participation group (PPG). The results from the 2014 patient survey had been reviewed progress to date fed back. For example, the GP partners were committed to raising awareness of the many appointment options available so that patients registered with the practice understood how flexible the service was for patients. PPG members we met at the inspection told us this was crucial to educate people and change their thinking about the other options of support available in the community so the practice resources were appropriately used.

Tackling inequity and promoting equality

Records showed that the practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events. The practice had access to online and telephone translation services. Staff understood how to access this service, but told us this was rarely used as patients whose first language was not English tended to bring a family member or friend with them to provide translation.

The premises were purpose built and services had been adapted to meet the needs of patient with disabilities. Treatment and consultation rooms were all situated on the ground floor and could be accessed easily. There was lift access to the first floor, which could be used by patients using mobility aids. Accessible toilet facilities were available for patients attending the practice and included baby changing facilities.

Patients who lived in isolated circumstances and found it difficult to travel to the practice were able to have their health reviews done at their own home. We saw records showing the allocation of appointments available each day for the week of the inspection. This showed that practice set aside home appointments specifically for the purpose of carrying out health reviews.

The locality had a violent patient scheme to which the practice could refer patients. However, to meet individual needs and reduce the impact for patients the practice had facilitated this scheme being run at the practice. Patients were able to still be seen safely at the practice, supported by external mental health workers and security staff at quieter times of the day. In the month preceding the inspection, one patient had been seen at the practice through this scheme.

Access to the service

All 25 comment cards and 34 patients we spoke with were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice.

The practice understood the needs of the patient list and the challenges of the rural location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. Three GP partners and a nurse practitioner had undertaken specialist training to carry out microsuction for patients, which is a procedure usually done in hospitals to remove hardened ear wax. The practice hosted specialist clinics at the practice for procedures normally offered at the main hospital (29 miles away) such as diabetic retinal screening held 3-4 times a year, regular hospital nurse specialist appointments for patients with complex diabetes and leg ulcer treatment.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Staff at the practice were skilled in assessing patients mental well being. They promoted talking therapies and signposted patients to counselling services such as the depression and anxiety service (DAS). The practice provided facilities for counsellors from DAS to use so that patients were able to access appointments nearer to home. Flexible appointments were available for patients coming to terms with bereavement and anxiety and depression. The practice recognised that access to psychological therapies was limited, so had looked at ways to meet this for patients for example by hosting a private counselling service by renting room facilities. Patients who wished to do so paid privately for this service, which was available closer to home avoiding them having to travel approximately 25 miles for this.

Access for working patients was facilitated through the availability of early morning appointments every day of the week and weekend clinics(flu vaccination). Patients were able to request repeat prescriptions and appointments online and sms texting was used for appointment reminders and blood test results. The practice performance for delivering appointments exceed what was expected. On average 1482 patient appointments were delivered each month, compared with 802 appointments expected for the list size. GPs carried out an average of four home visits each per day, travelling up to 15 miles on rural roads to reach patients in need.

The practice coverage was all rural covering 250 square miles (largest nationally). With the challenges of rural travel and sometimes hard to access areas, patient satisfaction was very high. The patient list was managed in a way to avoid any barriers, for example patients who moved out of area were able to remain registered with the practice for continuity of care and treatment.

The practice provided a rapid response service and emergency care to patients involved in road traffic accidents until the ambulance or air ambulance service could arrive.

Parents told us appointments were available outside of school hours for their children to minimise disruption to the school day.

The practice also had extended opening every day, providing early appointments from 7.30 am to avoid disruption for working patients. The practice offered flexible, 10, 15 or 20 minute or longer appointments for patients if needed. Staff demonstrated sensitivity towards patient mental health needs and booked appointments at quieter times of the day. The practice had an online appointment booking system and appointments were available before the main surgery times twice a week. Telephone appointments were available and the practice remained open to patients over the lunchtime period between appointment sessions. Other online services such as ordering repeat prescriptions were available to patients on the practice website.

The practice was innovative in promoting collaborative working with other agencies to improve outcomes for patients. Significant challenges were overcome by the practice, which facilitated well co-ordinated safeguarding and management of patients with complex care needs. Social services were able to use the practice facilities for safeguarding strategy meetings, which had further enhanced working relationships. Patients, particularly women experiencing domestic violence were able to access discreet face to face social care support at the practice once a week if they preferred this. Holsworthy Doctors held monthly multidisciplinary meetings, which included hospital specialists from the palliative care team. They had leased land to a charity and a satellite day hospice was being built next to the practice which will provide easier access for patients in need of support and end of life care. Data showed 100% of all patients newly discharged from hospital following an emergency admission were visited within 24 hours by GPs from the practice to ensure they had appropriate care, treatment and support.

Home visits were made to eight local care homes each week, by a named GP and to those patients who needed one.

Listening and learning from concerns & complaints

The practice took all complaints seriously and saw these as opportunities for learning. Systems were 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. A GP partner took the lead regarding quality assurance, which also included reviewing and disseminating learning from complaints.

Information was available to help patients understand the complaints system and included guidance about

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

escalating concerns if they were not happy with the practice response. Posters were displayed and leaflets summarising the system were given to new patients. All of the 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 an audit the practice had completed which looked at complaints received in the last 12 months. This showed 11 complaints were satisfactorily handled and dealt with in a timely way. The practice was open and transparent in dealing with complaints and viewed this in a positive way to improve the service. The practice manager explained that a meeting was always offered to the patient raising concerns to discuss these further and written feedback sent on completion. The review of complaints helped the practice to detect themes or trends and these were identified as being about administration, clinical or prescribing. Lessons learned from individual complaints had been acted on, for example resulting in named secretarial staff being linked to each GP and made known to the patients on the GP's list. All of the 34 patients we met told us this system worked very well because if they had an concerns or needed to follow up an issue they knew who to approach.

Are services well-led?

Outstanding ☆

(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 strong vision to deliver high quality care and promote good outcomes for patients. The vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in a leaflet given to new patients. The practice vision offered an accessible and caring service, in which patients were treated promptly and with courtesy . We spoke with 21 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

We met the chair person and three other members of the patient participation group, as well as receiving feedback from 59 patients in person or writing. Patients shared many positive examples of the way staff treated them and found the practice efficient.

Governance arrangements

There was a strong leadership structure with a scheme of delegation of responsibilities for policies and procedures. Partners at the practice had oversight of each area. For example, a GP partner was the lead for quality assurance covering all aspects of risks including dissemination of learning from complaints and serious events analysis. Quality assurance meetings were held regularly and we saw minutes for November 2014. Staff confirmed the minutes of these meetings and practice policies were electronically accessible on the practice intranet. We looked at eight policies and procedures. All of the policies and procedures we looked at had a named GP partner or practice manager partner as the lead, had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was consistently performing in line or better than expected with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. For example, prescribing of medicines was closely monitored to ensure decisions about prescribing were evidence based and value for money.

Holsworthy Doctors had close links with the universities as a teaching practice. Clinical audits were undertaken which it used to monitor quality and systems to identify where action should be taken. We noted that these were completed two cycle audits. For example, inadequate cervical cytology results were reviewed annually across the whole team highlighting areas for improvement. In addition to this, methods for engaging with female patients had been reviewed and changes made to improve the update of cervical screening. The practice had a much higher uptake of 90.6% female patients having cervical screening in the last five years when compared to national and local data (60% and 68%).

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. Health and safety risks were taken very seriously and included a slip hazard for patients and visitors on the path leading to the premises, which had been addressed. Display screen equipment assessments had been undertaken and identified specific training and/or equipment staff required and there was a plan in place to address this. Complaints and feedback from patients were also reviewed and issues added to the risk log where necessary.

The practice had a formal structure for governance and business meetings between partners, which was held monthly. We looked at the minutes of two of these meetings, which showed GP partners and the practice manager partner had oversight of all issues. Discussions about safeguarding issues, complaints, serious events, other potential risks to the business and areas for development were recorded within the minutes.

Leadership, openness and transparency

We reviewed minutes of team meetings prior to the inspection. These showed meetings were held regularly, at least monthly for the administrative and clinical teams and included trainee and student doctors. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. GPs and the nursing team held a daily meeting over coffee to discuss any issues. There was an open invitation for community nursing and social care staff to join these if they had any concerns about patients or any other issues. Team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example recruitment and induction policy which were in place to support staff. We were shown the electronic staff

Are services well-led?

Outstanding ☆

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

handbook, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required and confirmed they had received an induction when they started working at the practice.

Seeking and acting on feedback from patients, public and staff

The practice had strong leadership in place with a lead GP partner responsible for overseeing patient feedback including complaints. The GP responsible for this explained that they always offered a one to one meeting to discuss any concerns or feedback with a patient once an investigation had been completed. We looked at a log of complaints and concerns which showed this was taking place.

Fifty nine patient gave feedback at the inspection, in person (34) or in writing (25). All confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Many of the patients we met said their care was exceptional and outstanding and they had been listened to. They told us that they found the reception staff to be helpful and caring. The practice was said to be very efficient and well run. Patients told us that appointments were easy to access and when urgent care was needed it was immediate and reassuring.

The practice had gathered feedback from patients through patient surveys, complaints and compliments received. The partners had chosen to start the 'Friends and Family test' ahead of when the practice was required to and had reviewed two months of results by the time we inspected. We looked at the results of the annual national GP survey for 2014, which 266 patients provided responses for. High levels of satisfaction were seen in the responses to the national GP survey. Access to the practice was very good and patients could see a GP quickly. 93% of patients reported that their overall experience of their GP surgery was fairly good or very good. All of the feedback was positive.

The practice had an active virtual patient participation group (PPG) which had a membership of approximately 50 patients. The virtual PPG included representatives from various population groups; patients with long term and mental health conditions, older and disabled people, mothers and young people. Ten members of the group also met quarterly with GP partners and were in close contact with the practice manager via email. We met the chair person and three members of the PPG at the inspection and they told us the partners at the practice listened and were keen to make improvements for patients. For example, learning from complaints and proposed actions was being shared with the group within three weeks of a complaint being resolved. Patients were consulted about proposed developments at the practice and spoke about the combined efforts all of the GP partners and staff had gone to in working with the local hospice to facilitate the development of a day hospice for Holsworthy. The practice manager showed us the analysis of the last patient survey. The results and actions agreed from these surveys were available on the practice website. The practice had acted on comments, for example in developing a buddy system so that patients could be offered an alternative named nurse or GP to see in the event of delays whilst they were waiting to see them.

There was a low turnover of staff at the practice. The practice recruitment procedure did not involve patients in the shortlisting or interview panel, which we felt could be an area for development.

The practice had gathered feedback from staff through staff away days, staff meetings, appraisals and informal discussions. There was an open culture and staff told us they did not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Minutes of all the meetings we reviewed showed there was a clear process of reporting progress back to staff and linking issues across the whole team.

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

Holsworthy Doctors had a strong culture of reflective learning. All of the staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. For example two advanced nurse practitioners had completed a master class update, which covered infections, antibiotics and skin diseases and had other training booked linked to their development plan.

Are services well-led?

Outstanding ☆

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

The practice was a GP training practice so provided placements for pre qualification medical students and GPs in training. However, at the time of the inspection there we did not meet any students or GPs in training at the practice as they were not on duty that day. Two GP partners were qualified trainers and had time set aside for their own development in this role. These sessions were covered internally or by locum GPs.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, a patient had made a complaint about their experiences of a clinical procedure which resulted in changes. These changes included offering a patient choice about who they wished to have to do such procedures and improved recording of consent.

In their lead role, the GP partner overseeing complaints told us they had identified a theme around communication. Solutions to improve communication with patients included providing staff with additional customer care training, role modelling appropriate behaviours and role playing scenarios of difficult interactions. Scripts for staff to use in various scenarios providing guidance for staff were being written when we inspected