Neetside Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Neetside Surgery on 6 January 2015. This was a comprehensive inspection. The practice is based at Neetside Surgery and provides primary medical services to people living in the town of Bude and surrounding villages in Cornwall. The practice GPs have sole responsibility for managing 11-16 inpatient beds at Stratton Community Hospital. The practice provides services to a diverse population, covering an area of approximately 50 square miles.

At the time of our inspection there were 4,300 patients registered at the service with a team of two GP partners and two salaried GPs. Neetside Surgery is a training practice. When we inspected there were no students on GP training placements at the practice.

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

Overall the practice is rated as Outstanding.

Specifically, we found the practice to be good for providing safe, caring and well led services. We found the practice to be providing outstanding services in respect of being effective and responsive. It was outstanding for providing services to older people, people with long term conditions and people with mental health needs including dementia. The practice was good for families, babies children and young people and working age and vulnerable people.

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

- There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients. A named GP and nurse monitored the health and well being of vulnerable patients with a learning disability and/or complex mental health needs. Patient reviews were routinely carried out in their own homes, some of the patients lived in care homes in the local area. This promoted a trusting rapport with patients and had increased patient involvement in the

Summary of findings

management their health and well being. Practice nurses also routinely visited vulnerable patients in their homes to review and deliver care to them because they were too frail to attend the practice

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available the same day and staff were flexible and found same day gaps for patients needing routine appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Audits were used by the practice to identify where improvements were required. Action plans were put into place, followed through and audits repeated to ensure that improvements had been made.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- The practice was responsive to patients needs in providing a flexible and extended service for the whole population. For example, equipment been had obtained to provide greater access to health monitoring. This included a centrifuge, which had increased the lifespan of blood samples so that patients did not have to travel for up to five hours on public transport to the local hospital. In the summer months the demand on the practice could increase by a third at the height of summer, with over a 500 temporary patients, as Bude is a popular holiday resort. The practice strived to ensure that the services provided to patients was not affected by the seasonal impact of the influx of patients.
- The practice takes a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. For example, the practice supported a high percentage of patients needing palliative care support due to the remote setting, overseen by a GP partner who holds qualifications and has extensive experience in the field.
- All staff were actively engaged in activities to monitor and improve quality and health outcomes for people. For example, data showed the percentage of patients with diabetes who had reviews was better than the national average at 93.3% compared with 77.7%. The practice provided patients with an insulin passport, which contained comprehensive information about how to safely manage this condition and maintain good health. Retinal eye screening was being held at the practice each year to reduce the risk for patients in developing diabetic retinopathy.
- Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health. For example, during an audit of patients on anticlotting medicines the practice identified a number of factors influenced blood results.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff, and recruitment practices ensured that staff were fit to work at the practice or safe to carry out chaperone duties.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. The practice takes a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. This included assessing capacity and promoting good health. Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health.

Neetside is a training practice and the quality of training and support provided for trainee GPs and doctors was rated highly by the deanery. Staff had received training appropriate to their roles and encouraged to extend these with any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams, which included strong links with other health and social care professionals supporting patients at the end of their lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed patients rated the practice higher than others for some aspects of care. Twenty eight CQC comments cards reviewed and discussion with eleven patients on the day all provided positive feedback. A common theme was that the staff were extremely person-centred and patients were always treated with respect and compassion. This was borne out in the way staff engaged with patients with complex communication needs and frailty due to age and/or health conditions. Patients told us that staff went the extra mile.

Summary of findings

Staff we spoke with were aware of the importance of providing patients with privacy. Information was available to help patients understand the care available to them.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

The practice was responsive to patients needs in providing a flexible and extended service for the whole population. For example, equipment been had obtained to provide greater access to health monitoring. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The impact of a large number of temporary residents during the summer months was lessened for patients by increasing the availability of staff during this period. The practice had good facilities and was well equipped to treat patients and meet their needs. Patients told us the staff went beyond what was expected of them and we saw many examples of this. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was reviewed and acted upon.

Are services well-led?

Good 

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

The practice had a clear vision and strategy, which inspired the team to have a shared purpose of providing high quality care. There was a clear leadership structure and staff felt supported by management to develop and extend their skills to achieve this. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

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

The practice was directly involved in a pilot with Stratton Medical Centre to develop integrated care services by working together with voluntary, health and care services to offer a combination of medical and non-medical support. This included a volunteer led befriending service for vulnerable people. It was too early in this process to determine the impact this might have for patients at the practice.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients nearing the end of their lives. Innovative approaches were used, such as the use of aromatherapy to enhance patient well being.

Nationally reported data showed that outcomes for patients exceeded expectations for conditions commonly found in older people. For example, 100% compared with the national average of 81.3% of patients aged 75 or over with a fragility fracture were treated with an appropriate bone-sparing agent.

Patients were experiencing proactive management of emergency and short term pain relief medicine by reviewing this with the patient at intervals suited to their individual needs.

Patients with complex care needs were well monitored by the practice working in partnership with other agencies. The staff were responsive to the needs of older people, and offered GP home visits and rapid access appointments for those with enhanced needs. Practice nurses were also routinely doing home visits to vulnerable frail patients where needed to deliver treatments and care, which could not be provided by the community nursing team. For example, practice nurses had the experience and qualifications to perform specific examinations and treatments for older women and had arranged to see a patient at home on the day of the inspection.

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

Summary of findings

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

Pneumococcal vaccination was provided at the practice for older people. In 2014, the practice had run 26 flu clinics as well as the standard week day appointments. Shingles vaccinations were also provided to patients who fit the age criteria. Patients were contacted to offer them the opportunity to make an appointment to have the vaccination, which had increased the uptake of patients being given this.

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

The practice worked in collaboration with the local church to distribute food vouchers to vulnerable older people with limited financial resources. This was done compassionately and patients in this position were treated with dignity.

People with long term conditions

Outstanding ☆

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

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

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health. For example, during an audit of patients on anticlotting medicines the practice identified a number of factors influenced blood results. A healthcare assistant was supported by GPs to produce a validated information sheet about the dietary impact of foods containing vitamin K. Patients were given this information to help them understand the risks with their diet and medication. It included information about the correct daily portions and values of vitamin K and how this could affect the potency of the medication and therefore increase their blood clotting time.

Summary of findings

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

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

The practice had links with the external health care professionals to provide advice and guidance as required. GPs and nurses from the practice attended a quarterly virtual Diabetic clinic with hospital specialists, to review patient care and treatment.

Health education around diet and lifestyle was promoted by the practice. The practice took an early intervention approach and helped identify and signpost patients to external support. This included assistance with smoking cessation and contact details for the health worker running this was given to patients.

Families, children and young people

Good

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

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

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The waiting room had toys for children to play with whilst waiting for their appointments.

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

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

Summary of findings

The practice was designated as a young person friendly practice having achieved quality standards for information and support available. For example, information about contraception and promotion of health was targeted for young people. Young people had access to information and could request chlamydia screening and be seen by a practice nurse specifically trained in these areas.

Support was being accessed for parents from child specialist workers and parenting support groups where relevant.

The practice was proactive in getting feedback from patients and the patient participation group included parents with young families.

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

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was developing the service so that working patients would be able to book appointments and repeat prescriptions on-line. The practice website offered information about the full range of health promotion and screening available for this group. For example, the practice had extended opening every Monday evening for working patients. Appointments were available for patients to see a GP, practice nurse or health assistant. Patients would be able to request repeat prescriptions on-line within a month, at the local pharmacy or in person at the practice. Repeat prescriptions were being given for up to a month.

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

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

Summary of findings

The practice was proactive in seeking feedback and the patient participation group at the practice included working age members.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability and their carers for reviews. Home visits by GPs and practice nurse were carried out routinely each week and jointly with the community nursing team to reduce stress and improve communication. The practice liaised closely with the learning disability nurse specialist to ensure information was communicated in a person centred way, for example in easy read or picture formats.

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

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

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

People experiencing poor mental health (including people with dementia)

Outstanding

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

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

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

Staff were skilled in recognising and responding to patients experiencing mental health crisis, providing support to access emergency care and treatment. The practice worked collaboratively

with the community mental health team and consultant psychiatrists from the mental health partnership trust. Joint reviews were carried out every month which looked at changing risk, to monitor patient safety and mental well being.

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

Advice and support was sought as appropriate from the psychiatric team with referrals made for psychiatry review or entry into counselling. Patients may be encouraged to refer themselves to the counselling service. Information about depression, including a diagnostic questionnaire was available on the practice website for patients to see and use. Patients found this helpful and made them more aware of when to seek help from their GP.

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

Early identification of patients with suspected dementia were being screened and referred to the memory clinic for diagnostic tests. Data showed the practice was above the national average of 54.3% at 60.1% in diagnosing people with dementia. Patients had care plans in place, which supported their on-going changing needs and those of their carers. The practice worked closely with a social centre in Bude to provide services to support patients experiencing poor mental health.

Summary of findings

What people who use the service say

The practice sought feedback from patients in several ways. Three surveys, including the 2014 national GP survey showed that results for Neetside Surgery was better in all areas compared to the clinical commissioning group (CCG) and national average. Patient satisfaction was much higher than the national average, 98.2% compared with 86% in the 2014 GP survey.

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

inspection. Our comment box was displayed and comment cards had been made available for patients to share their experiences with us. Thirty nine patients gave feedback at the inspection, in person (11) or in writing (28). All confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

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

These findings were reflected during our discussion with the PPG members. The PPG members told us the group had a good working relationship with the GP partners. The group had been enabled to be independent and had developed a statement of aims. These aims included increasing patient involvement, facilitating the improvement of services and fostering patient loyalty and support for the practice.

All of the patients who gave verbal feedback gave high praise for the treatment and support they received at the practice. Patients stated they were very happy and were treated with respect and dignity. They told us that the GPs and practice nurses were excellent and thorough when it came to diagnosis, treatment and on-going monitoring of long term health conditions.

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

The appointment system was praised by patients, who told us it was easy to make an appointment. Patients were well informed of developments and knew that the practice was about to provide an online appointment booking system via the practice website. Several remarked that this would improve the service further.

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

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

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

Areas for improvement

Summary of findings

Outstanding practice

- The practice was responsive to patients needs in providing a flexible and extended service for the whole population. For example, equipment been had obtained to provide greater access to health monitoring. This included a centrifuge, which had increased the lifespan of blood samples so that patients did not have to travel for up to five hours on public transport to the local hospital. In the summer months the demand on the practice could increase by a third at the height of summer, with over a 500 temporary patients, as Bude is a popular holiday resort. The practice strived to ensure that the services provided to patients was not affected by the seasonal impact of the influx of patients.
- The practice takes a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. For example, the practice supported a high percentage of patients needing palliative care support due to the remote setting, overseen by a GP partner who holds qualifications and has extensive experience in the field. Innovative approaches such the use of aromatherapy were being used to enhance patient well being.
- All staff were actively engaged in activities to monitor and improve quality and health outcomes for people. For example, data showed the percentage of patients with diabetes who had reviews was better than the national average at 93.3% compared with 77.7%. The practice provided patients with an insulin passport, which contained comprehensive information about how to safely manage this condition and maintain good health. Retinal eye screening was being held at the practice each year to reduce the risk for patients in developing diabetic retinopathy.
- Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health. For example, during an audit of patients on anticlotting medicines the practice identified a number of factors influenced blood results.

Neetside Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and another specialist advisor who was a practice manager.

Background to Neetside Surgery

The GP partnership run the practice from Neetside Surgery and provide primary medical services to people living in the town of Bude and the surrounding villages. The GPs have sole responsibility for managing 10 inpatient beds at Stratton Community Hospital.

At the time of our inspection there were approximately 4,300 patients registered at the practice. There is a higher percentage of patients over 55 years when compared to national statistics. The practice is placed within the mid range of the social deprivation scale.

The practice is contracted to provide personal medical services and includes enhanced services such as extended hours, facilitating timely diagnosis and support for people with dementia, influenza and

pneumococcal Immunisations, rotavirus and shingles vaccination, remote care monitoring, identification of people with learning disabilities. There are two GP partners, a male and female, who held managerial and financial responsibility for running the business. Two male salaried GPs work part time. Neetside Surgery is a training practice, with one GP partner approved to provide vocational training for GPs, second year post qualification doctors and medical students. There were no GPs in training or medical students on placement when we inspected the practice. The GPs were supported by two registered nurses, a healthcare assistant/phlebotomist, a practice manager, additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

Needside Surgery is open from 8.30 am - 6pm Monday to Friday. Extended opening hours are held every Monday from 6.30pm to7pm providing appointments for working patients. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Kernow clinical commissioning group.

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

Detailed findings

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 6 January 2015.

During our visit we spoke with four GPs, the practice manager, two registered nurses, a phlebotomist, administrative and reception staff. We also spoke with 11 patients who used the practice and met two representatives of the patient participation group. We observed how patients were being cared for and reviewed 28 comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we reviewed these. Significant events were discussed every week at the GPs meeting and the formal review process was a standing item on the practice meeting agenda every month. Minutes recorded actions from past significant events and complaints. Learning from significant was shared verbally with relevant staff and changes made. Whilst staff knew how to raise an issue for consideration at the meetings and were encouraged to do so, we highlighted that there was no formal process for communication of the minutes showing analysis and actions taken. Data shared with us at the inspection showed the practice list was increasing by 10% each year and had resulted in the expansion of the team of staff. In feedback, we highlighted that a formal communication process showing the in-depth analysis of significant events and actions taken would provide an audit trail for the practice demonstrating raised awareness and mitigation of potential risks in the future.

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 two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example the practice had reviewed the system for issuing repeat prescriptions following a nurse led review of a patient with chronic respiratory disease, which found they had been continuously prescribed steroid medication on repeat prescriptions without sufficient reviews of the patient taking place.

National patient safety alerts were disseminated by email to practice staff. For example, a recent alert about medicine used to allay symptoms of nausea and vomiting for patients had been circulated. The prescribing lead GP explained that a list of patients prescribed this medicine was produced. The named GPs for each patient had been asked to review the medicines with them and make changes where necessary.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff had received relevant role specific training on safeguarding. GPs, nurses and administrative staff were able to describe recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed specific GPs as 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 one GP partner had completed training at level 3 for safeguarding vulnerable children. The other GP partner had plans in place to complete this as part of the revalidation of their qualification 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 linked with other siblings and family members registered at the practice. GPs were using the required codes appropriately on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans

were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Where required concerns were discussed and an alert made to the local authority safeguarding team for further investigation.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including the health care assistant/phlebotomist had been trained to be a chaperone. Reception staff did not act as chaperones.

Medicines management

Medicines were stored securely in the treatment rooms and medicine refrigerators and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Nursing staff were responsible for monitoring these and knew the safe temperature range for storing medicines. Records for the previous month demonstrated that refrigerators were operating within the safe range described by staff.

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

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

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

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice had an additional monitoring safety system. GPs reviewed results and signed off any changes to dose, which were then communicated with the patient. As part of this process, patients were closely monitored to ensure they contacted the practice for their results so that they could be given advice about altering the dose of medicines they were taking. An administrator was allocated each day to carry out this task and if a patient had not contacted the practice by 5pm, staff telephoned the patient. If this proved unsuccessful, the patient's named GP was informed immediately. For example, four patients on anti blooding clotting medicines received their results and advice from their named GP about the dose they should now be taking. Staff rang a patient when they failed to contact the practice for this information.

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

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely.

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

Cleanliness and infection control

The premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. In 28 comment cards, all of the patients remarked that they were satisfied with the standard of cleanliness at the practice. All 11 patients we spoke with were also satisfied with the cleanliness and infection control at the practice.

The practice had a lead nurse 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. New staff had received induction training about infection control specific to their role. The lead nurse had carried out audits for each of the last three years and improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and the actions implemented. For example, the most recent audit concluded that improvements were needed in the way specimen samples were handled. The procedure for handling specimen samples had been reviewed to promote safety and reduce risk of cross infection.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff described how they would use these to comply with the practice's infection control policy. For example, we saw there was a designated box for patients to put samples in and a protocol followed each time it was emptied. Nursing staff handled the samples, carried out checks and then safely disposed of the contents. The practice had a needle stick injury policy in place and staff knew the procedure to follow in the event of an injury. We saw the practice used needles with an integral safety sheath, which was in line with current practice.

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

The infection control protocol made reference to other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessment. Records showed that the practice was following suitable procedures for the management, testing and investigation of legionella. This is a bacterium that can grow in contaminated water and can be potentially fatal. The practice was carrying out regular checks in line with national guidance to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records demonstrated this was happening. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and certain types of equipment were calibrated for accuracy for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Information provided by the practice showed that staff retention at Neetside was very high. All of the staff told us they enjoyed working at the practice and new staff had been recruited due to the 10% increase in patients being added to the list each year. Appropriate checks had been undertaken consistently in all the staff files we looked at. For example, all three files contained a criminal record check using the Disclosure and Barring Service (DBS). References had been obtained from previous employers and immunisation, professional registration and indemnity insurance information checked at the point of employment. Records demonstrated that professional registration checks for nursing staff were carried out annually and revalidation dates for GPs were known and being monitored.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for all members of staff to cover each other's annual leave and periods of sickness.

Staff told us there were enough staff to maintain the smooth running of the practice and to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

out, for example fire safety equipment had been tested in the last 12 months. Staff training records demonstrated that all staff had completed an induction and fire training, including a drill.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. In feedback cards, two patients specifically described their experience of being treated when their health deteriorated. Both patients commented that they were seen immediately, treated quickly and were reassured by the staff attending them. Staff gave us examples of referrals made for patients whose health deteriorated suddenly and this was supported by patients comments. For example, we looked at records about a significant event which demonstrated that staff recognised and took action to reduce risks for a patient who was in crisis with their mental health. Records showed that the patient's care plan and risk assessment was reviewed with them after the event. Further early warning signs of mental distress had been added to their care plan, which set out clear boundaries of accepted behaviour.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records demonstrated that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, suspected meningitis, hypoglycaemia, severe asthma, overdose, nausea and vomiting and epileptic fit. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. The practice manager and GP partner explained that they had been trying to source a replacement for medicine used to reduce inflammation since December 2014 from wholesale pharmacies used to supply medicines in Devon and Cornwall but had been unsuccessful. A risk assessment had been done, which highlighted that this medicine was rarely used because other first line emergency treatment was available and in date.

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

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The last fire drill had taken place 18 months previously in 2013. Five out of 14 staff listed on the training matrix had completed fire training in the previous 12 months. However, the practice manager verified that fire training was provided every 24 months as per the practice fire risk assessment. Therefore, the practice was two thirds of the way through the training cycle.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff were able to give clear rationale for their approaches to treatment. They were familiar with current practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Weekly meetings were held at which the latest guidelines and research was discussed. For example, a GP led a discussion about the care of a patient with a life threatening condition which had been difficult to diagnose due to the presentation of symptoms. In discussion, GPs identified learning points from this situation. They told us this had highlighted the importance of keeping an open mind when a patient's symptoms did not fit into a usual pattern with which to make a diagnosis. Our discussions with the GPs and nurses demonstrated that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as end of life care, diabetes, heart disease and asthma. GPs told us that the practice had a strong historical tradition in leading innovation in areas such as palliative care. For example, a GP partner held alternative therapy qualifications so was able to provide aromatherapy for patients receiving end of life care. Practice nurses had additional qualifications which allowed the practice to focus on specific conditions. For example, a practice nurse who held a diploma in asthma and chronic respiratory disease was responsible for managing the care of patients with these long term conditions. Data for the local CCG showed that the practice performance for monitoring patients with long term conditions was comparable with other practices.

Data from the local CCG of the practice's performance for antibiotic prescribing demonstrated that this was comparable to similar practices (27% versus national rate of 28%). The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients every week and had on site meetings with other health and social care professionals supporting them.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data showed that the practice was performing well in preventing unplanned admissions for vulnerable patients (9.5% compared with national average of 13.6%). Data seen also showed that patients with suspected cancers were referred and seen within two weeks. GPs told us they asked patients to immediately notify them if the hospital had not given them an appointment within the two week period. We saw examples of where GPs had chased up urgent appointments at the hospital and three comment cards from patients also confirmed this was done.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Patients in written and verbal feedback gave us examples of this. For example, patients told us they were treated as individual's and their views respected.

Management, monitoring and improving outcomes for people

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

The practice showed us a copy of the latest teaching practice report carried out in 2014 by the Peninsula Medical Deanery, which demonstrated that GPs used an evidence based approach and utilise every opportunity to review and improve their practice. GPs showed us three clinical audits that had been undertaken in the last three years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. For example, the practice was mid way through poly pharmacy audit for the most vulnerable patients age 75 and over living in care homes. The first audit showed that GPs identified all patients taking 7-10 different medications, which could increase risks for patients for example making them more prone to falls. The audit rationalised the need to increase the frequency of comprehensive reviews, which were normally done on an annual basis. The practice had implemented a quarterly search of patients and had more dates scheduled for comprehensive medication reviews to be completed for patients living at adult social care homes. A second audit was scheduled to take place.

There was a protocol for repeat prescribing which was in line with current national guidance. Repeat prescription requests were reviewed daily and signed off by a GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had implemented the gold standards framework for end of life care. The practice has sole responsibility for managing the use of beds at Stratton community hospital, which was temporarily closed for refurbishment. GPs told us that a high percentage of patients using the hospital needed palliative care support. The nearest hospices to the practice were in Barnstaple and Truro, so the team of GPs worked closely with the palliative care team to support patients to be at home and receive services there. One of the GPs specialised in palliative care and had extended their skills in this field by obtaining further qualifications, for example they held a post graduate diploma in palliative medicine. The GP told us they used these skills to enhance holistic care for patients to promote their mental well being and comfort. A palliative care register was held and reviewed regularly. This included weekly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term medical conditions were offered a minimum of yearly health reviews. Nurses told us that the frequency of these reviews were agreed with patients and dependent upon their health needs. For example, data showed that the percentage of patients with diabetes who had reviews was better than the national average at 93.3% compared with 77.7%. The practice provided patients with an insulin passport, which contained comprehensive information about how to safely manage this and maintain good health.

The practice had systems in place to monitor and improve outcomes for patients. For example, the nursing team had carried out an audit of patients on anti clotting medicines. This identified patients whose blood results went outside of the safe target range and enabled the practice to identify the factors causing this. From this information, the team found a number of factors influenced patient blood results for example poor patient engagement in self management and lifestyle issues such as diet. The main cause found related to diet and a healthcare assistant was supported by GPs to produce a validated information sheet about the dietary impact of foods containing vitamin K. Patients were given this information to help them understand the risks with their diet and medication. It included information about the correct daily portions and values of vitamin K and how this could affect the potency of the medication and therefore increase their blood clotting time.

An annual flu vaccination programme was underway when we inspected. This included older patients, those with a long term medical condition, pregnant women, babies and young children. For patients within the relevant age range a vaccination against shingles was also available and information about this highlighted in the practice newsletter and website. The practice held additional clinics for vaccination as well as when patients attended for other appointments so they did not have to make unnecessary trips to the practice. Patients were contacted via text, phone or email. Data showed that 99.2% diabetic patients had been vaccinated against flu compared with the national average of 93.5%. The success of the programme was shared with staff at practice meetings, for example minutes of these in December 2014 reported that at that point only 20 patients had not attended for flu vaccination and were being contacted again.

Data showed 95% of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 93.1% which was higher than the national average of 82%.

Effective staffing

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

All staff undertook annual appraisals with the practice manager and a GP, which included identification of individual learning needs. Mandatory training was provided on-line and some staff showed us their training records and paper portfolios with certificates of completed courses. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one member of staff had completed a phlebotomy course at the local university.

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

Working with colleagues and other services

The practice was directly involved in a pilot with Stratton community hospital to develop integrated care services by working together with voluntary, health and care services to offer a combination of medical and non-medical support.

GPs worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. There were policies in place outlining the responsibilities of all relevant staff in passing on, reading and taking action about any issues arising from communications with other care providers on the day they were received. All of the GPs were responsible for seeing these documents and results and for taking action required. Staff understood their roles and felt the system in place worked well and our observations supported this. Results and discharge summaries were followed up appropriately and in a timely way. For example, we observed a GP reviewing patient results immediately in between appointments and recording actions to be taken, which included contacting a patient for a follow up appointment. The practice had a safety net system in place, which meant that patient results and correspondence was only dealt with by permanent GPs working at the practice for continuity of care. In feedback, we highlighted that the practice needed to consider whether this system would be sustainable as the list size continued to increase creating more demands on the team. The ability to audit and track tasks across the team in the IT system were not currently being utilised and GPs recognised this needed further development.

The practice worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children every month. Every three weeks there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team. The practice had a list of vulnerable adults and worked closely with community professionals. For example, the practice worked closely with learning disability nurse specialist to build a trusting rapport so that the health and wellbeing of patients with complex learning disabilities was monitored. Data showed that the practice

performed better than expected for completing annual health checks for patients with learning disabilities. Nurses explained that they regularly visited patients at two adult care homes to facilitate these and develop a trusting rapport with patients to reduce any anxieties they might have.

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. Special notes were shared with the 111 and Out of Hours services for patients with complex needs who needed continuity of care and treatment overnight.

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

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in promoting patient rights. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. For example, the team had worked closely with the learning disability nurse specialist to ensure information was set out in a format suitable for a patient. The practice used picture and easy read information when explaining procedures such as blood taking.

All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided. Two parents with children attending the practice confirmed that they were always present during consultations. They told us that all of the staff were good at engaging their child and treating them as individuals.

Procedures were in place for documentation of consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Nursing staff also recorded patient consent for procedures such as wound dressing, blood taking or cervical screening.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. This was young person friendly and in easy read formats. The practice website contained information and advice about other services which could support them. The practice offered new patients a health check with a nurse or with a GP if a patient was on specific medicines when they joined the practice. A patient attending the practice showed us the form they were completing and we saw this included obtaining information about their lifestyle and areas they might like help with. For this patient, we saw they had selected that they wanted assistance with smoking cessation and was given information immediately about the local smoking cessation clinic and contact details for the health worker running it.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received 28 completed cards and all were positive about the care and treatment experienced. Patients we spoke with (11) said they felt the practice offered exceptional services and staff were caring, helpful and professional. They said staff treated them with dignity and respect. Patients were complimentary about reception staff and told us that every effort was made to give them a same day appointment even for routine issues. Our observations of reception staff responding in person with patients or over the telephone also confirmed this.

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

Staff were discreet when discussing patients' treatments in order that confidential information was kept private. There were additional areas available should patients want to speak confidentially away from the reception area. We sat in the waiting room and observed patient experiences as they arrived for appointments. Reception staff were friendly and knowledgeable about patients and treated them with respect.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were able to explain how they diffused situations to avoid further escalation of a patients frustration or anger. They shared an example of how they had supported a patient with complex mental health needs. The locality had a violent patient scheme to which the practice could refer patients. However, to meet this patient's needs the practice had facilitated support for the person so they could be seen at the practice, with assistance from external mental health workers and security staff at quieter times of the day.

The practice worked closely with the local food bank and gave vouchers for food to families and patients in need. They did this discreetly and patients told us they found this very supportive during difficult financial times.

Care planning and involvement in decisions about care and treatment

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

Patient survey information demonstrated that the practice achieved a better than expected level of patient satisfaction and involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 94.7% of practice respondents said the GP involved them in care decisions and 93.4% felt the GP was good at explaining treatment and results.

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being good at listening to their needs and acting on their wishes. Patients said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 28 comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. Notices in the reception areas and information on the practice website explained the translation services available in a number of languages. Practice staff told us they recorded this information in the patient record and the most common language other then English was Polish.

Patient/carer support to cope emotionally with care and treatment

GP patient survey data showed 98.2% patients described the overall experience of their GP surgery as fairly good or very good, which was much higher than the national average of 87.5%. The 28 comment cards we received were consistent in describing positive experiences about the care and treatment they had received. Patients highlighted that staff responded compassionately when they needed help and described as going beyond what was expected of them. The practice offered referrals to a carers clinic run by a community support worker, to provide practical and emotional support for patients who were carers. Members

Good

Are services caring?

of the Patient Participation Group (PPG) told us that the practice also had good links with the voluntary sector, including a local drop in centre where patients could get additional support and advice.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Written information was also displayed in the waiting room explaining the various avenues of support available to carers.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The patients we spoke with gave us examples of the support received from practice staff when they had experienced difficult and challenging times in their lives. For example a patient who was also a carer for their spouse who had a long term condition described the emotional support from their GP. They told us the practice was reliable whenever they needed help and had supported them in getting additional financial and care help for their spouse.

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, the practice held registers for each group including one for vulnerable patients so that the support, care and treatment was patient centred.

The staff were responsive to the needs of older people, and offered GP home visits and rapid access appointments for those with enhanced needs. Practice nurses were also routinely doing home visits to vulnerable frail patients where needed to deliver treatments and care, which could not be provided by the community nursing team. For example, practice nurses had the experience and qualifications to perform specific examinations and treatments for older women and had arranged to see a patient at home on the day of the inspection.

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Operational meetings were held at the practice every month. We saw minutes for the December 2014 meeting, which showed that the practice had provided a report to NHS England about unplanned admissions of patients to hospital. This confirmed that patients had care plans in place. We saw other minutes showing that GPs worked in collaboration with other health and social care professionals to support these patients at home.

Twenty eight patients commented that the prescription system was good. When we inspected, the online request service was due to begin and patients had been informed about this improved service. We saw patients called in to collect their prescription and take it to a local chemist. The practice had arrangements in place for more vulnerable patients so that prescriptions were sent automatically to the chemist of choice. The chemist then delivered the medicines direct to the patient. All patients said the process was efficient and took a couple of days.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, GPs had responded to changing demands and had implemented more flexibility into the appointment system by staying opening late every Monday from 6.30-7pm. A GP, practice nurse and healthcare assistant were available to see working patients during late opening hours.

Tackling inequity and promoting equality

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

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed or were completing the equality and diversity training. All of the staff told us that equality and diversity was regularly discussed at staff appraisals and team events.

The practice was situated on the ground floor of a converted Methodist chapel. The premises presented some restrictions in terms of future development, but the practice had arrangements in place to ensure it was accessible for patients in wheelchairs with ramp access to the side of the premises. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and

consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had an audio loop in reception for those with hearing aids.

The practice had systems in place to support patients whose circumstances may make them vulnerable. For example, the practice had a register of patients who may be living in vulnerable circumstances, with specific information in individual records about potential risks and support that was needed. GPs told us there were no barriers for patients with "no fixed abode" and workarounds were in place to record contact information. Staff told us they tried to fit patients in for appointments if they presented on the day, making appointments accessible. Patients in 28 comment cards confirmed that this was also their experience of the appointment system.

GPs told us that the practice patient list could increase by up to a third at the height of summer, with over a 500 temporary patients, as it was situated in a popular holiday resort. The practice had increased the number of appointments available during these months and regular patients remained unaffected.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. A patient newsletter highlighted that the contact number for the practice had been changed and number of incoming/ outgoing lines increased as a result of patient feedback. Online services to book appointments through the practice website were due to be up and running soon after the inspection. All 11 patients we spoke with and two members of the PPG were aware of this development and thought it would improve access for people.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice had extended opening hours once a week every Monday from 6.30 – 7pm. Patients told us that GPs were very flexible, for example a patient told us their GP offered to see them early before morning appointments started as they had work commitments to get to.

Flexible arrangements were in place for working age patients, which extended the opportunities for health screening to take place at one appointment. Repeat prescribing requests could be made by patients in some circumstances for up to six months as appropriate.

Feedback cards completed by 28 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Eleven patients we spoke with told us the appointment system was accessible, by telephone, online or bookable in person. They confirmed urgent appointments were available on the same day. We saw reception staff answered the telephone to patients in a friendly way and were accommodating in getting them appointments to see the GPs or nurses.

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

Longer appointments were also available for patients who needed them and those with long-term conditions. For example, patients with learning disabilities and/or mental health needs were offered appointments at quieter times of the day and for longer periods. Counselling services were available on site provided by the local mental health partnership trust. Information was displayed in waiting areas for patients and highlighted they could self refer to these counselling services if they wished to.

The practice was in a coastal location, with limited transport links to the main hospital situated some 35 miles away. Samples were collected by courier each day at 11am and taken to the hospital for analysis. The practice had obtained equipment and developed team skills to increase patient access to blood screening and other tests normally carried out at the main hospital. For example, a centrifuge had been obtained, which had increased the lifespan of blood samples so that patients did not have to travel for up to five hours on public transport to the local hospital if the 11am collection was missed. Staff had undertaken advanced training and had access to equipment so that they could carry out 24 hour blood pressure monitoring.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice. We looked at six complaints received from patients, all of which had received a prompt acknowledgement and outcome in writing.

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

None of the eleven patients we spoke with, or 28 patients who gave written comments had ever made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of 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 the staff room. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Patients comments in person and in the 28 comment cards received confirmed this was their experience of the practice.

Staff morale was high and there was a low turnover of staff. As a training practice, Neetside had attracted interest from trainee GPs in becoming salaried staff as resources were increasing due to patient demands. Staff said they felt valued and were encouraged to be innovative to deliver safe and effective care and treatment for patients. The practice team was managed in an open and transparent way.

Governance arrangements

Statistical data showed that the practice was performing above national average in several areas, particularly with regard to monitoring patients with long term conditions. For example, the practice far exceeded the national average of patients with diabetes who had been reviewed, vaccinated against flu and held screening clinics to reduce risks for people with this condition. The practice was proactive in promoting the national cervical screening scheme for women between 25 and 65.

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

The practice had arrangements for identifying, recording and managing risks. Risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, difficulties in obtaining supplies of second line emergency medicines had been assessed and other wholesalers contacted. The practice resolved this issue soon after the inspection by obtaining replacement medication from the local hospital as the national supply shortage continued.

There was a clear leadership structure with named members of staff in lead roles overseeing potential areas of risk. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, knew there was a whistleblowing procedure and who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line and in some instances better than expected with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, infection control audits had been carried out annually. We discussed the findings from the audit carried out in April 2014. This highlighted that the age and construction of the building meant that impermeable floor covering could not be fitted above the skirting board.

Leadership, openness and transparency

Meetings were held regularly and minutes kept and circulated via email to the team. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Team building events were held regularly and

Are services well-led?

Good

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

included fundraising for charities associated supporting patients with long term conditions. For example, staff had done a sponsored bike ride to raise funds for a heart charity.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, induction policy and management of health and safety which were in place to support staff. For example, we looked at the induction pack used for locum staff which provided comprehensive information.

Seeking and acting on feedback from patients, public and staff

The importance of patient feedback was recognised and there was an active patient participation group (PPG), which worked in collaboration with a local charity for fundraising for a local food bank. Two members of the PPG said that there was a positive working relationship in which GP partners and practice manager listened and acted on suggestions made. Any potential barriers for change, which usually related to matters outside of their control such as NHS budget constraints were always explained. However, PPG members told us that the practice was open to improving the services for people in whatever way it could. Examples shared with us included the changes made to the appointment system to increase access for working people.

Plans to develop the services were openly discussed with the PPG such as being involved in development of a community hub for people living in and around Bude and Stratton.

Management lead through learning and improvement

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

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, nurses held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients, were reviewed. Mentoring and support was provided where needed to improve skills and accuracy with such testing.