Care Quality Commission

The Blackdown Practice

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?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Outstanding
Are services well-led?	Outstanding

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Blackdown Practice on 30 June 2016. Overall the practice is rated as outstanding.

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

- The practice had a strong communitarian approach.
- There was a strong commitment to providing co-ordinated, responsive and compassionate care for patients, particularly patients with long term conditions and older people who are frail and at risk of social isolation.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- There was a holistic approach to assessing, planning and delivering care and treatment to people using services. Examples included: risks to patients were assessed, well managed through the integrated approach to supporting patients who were vulnerable and/or had long term conditions.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Feedback from all of the 27 patients we spoke with or who provided feedback, who used the service, family members and carers, and stakeholders were continuously positive about the way staff treated them and other patients. Patients said staff went the extra mile and the care they received exceeded their expectations. Patient's also told us that it was easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients experienced flexible services that aimed to provide choice and continuity of care. The practice was mindful of the rural isolation of many of the

Summary of findings

patients and brought services closer to home. These included: Retinal screening for patients with diabetes to reduce the associated risks with this condition; All three sites were well equipped so that patients could access the same services at branch surgeries, such as ear irrigation or regular testing of patients with blood clotting conditions.

- The Blackdown Practice was proactive in identifying carers and had a comprehensive overview of their needs and created ways to provide timely support for them.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. Examples included: Collaboration with an adult social care provider to extend their services to include domiciliary care; driving up quality by collaborating with seven other GP practices in a federation.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw two areas of outstanding practice:

The practice was proactive in recognising the pressures on the NHS and a lack of adult social care services in the area and was a founding member of a patient focussed charity and continued to promote the services available to them. Patients had immediate and easy access to the many types of support available from the charity, including information, transport assistance support and social activities for vulnerable patients living in the community. Over 300 patients are supported each year by this service.

Integrated health and social care is strongly advocated and the practice has driven innovation in the integration of community services in the Blackdown Hills area through a long term health conditions project. The practice has developed a specific role of practice community matron providing patients with one point of contact and greater anticipatory care of vulnerable patients. This had reduced the number of unplanned hospital admissions by a third.

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?

The practice is rated as good for providing safe services.

Good

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

The practice is rated as good for providing effective services.

Good

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as outstanding for providing caring services.

Outstanding

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example, 91.5% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- Feedback from patients about their care and treatment was consistently and strongly positive. They shared many positive examples of inclusion and partnership with the GPs in making decisions about their care and treatment.

Summary of findings

- We observed a strong patient-centred culture.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.
- Information for patients about the services available was easy to understand and accessible.
- The practice was proactive in identifying carers, with 3% of the total patient numbers being supported. GPs had a comprehensive overview of their needs and created ways to provide timely support for them.
- Being a founding member of the Blackdown Support Group the GP partnership worked closely with the co-ordinator and volunteers to ensure patients received additional support such as befriending. Free accommodation was provided for the support group at the practice with telephone access.

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

Outstanding

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice focussed on providing resilient, proactive and responsive services for patients registered with it. The development of the long term conditions project had increased communication with all professionals, with the practice community matron being the key point of contact so that there is greater anticipatory care of vulnerable patients.
- The individual needs and preferences were central to the planning and delivery of tailored services. All 7450 patients had a named GP. The practice had an established GP buddy system to promote patient continuity of care. There was an individualised approach to triage, where the patient's GP or GP buddy telephoned the patient and/or their carer where appropriate to discuss their needs.
- There were high levels of patient satisfaction, which highlighted the services were flexible, proactive and met needs. For example, 96.47% of patients found it easy to get through to this practice by phone compared to the national average of 73%. 93.1% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.

Summary of findings

- Innovative approaches to providing person centred care involving other providers were evident at The Blackdown practice.Examples included: Collaboration and support of the only nearby adult social care provider to extend the service to include domiciliary care services in the area; Being a founding member of the Blackdown Support Group the GP partnership worked closely with the co-ordinator and volunteers to ensure patients received additional support such as befriending.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?
The practice is rated as outstanding for being well-led.

Outstanding

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The Blackdown practice provided a positive experience for GP registrars. Past reports from medical students about their placements were also positive. Through a good reputation of support with trainees and an approachable and dynamic leadership team. The practice had no difficulties recruiting new staff when staff retired or left.
- There was a strong leadership structure, which incorporated sound business management for the development of the practice.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice had a number of policies and procedures to govern activity and held regular governance meetings, which were inclusive with all staff groups represented by senior staff.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels.
- The GP partners demonstrated a strong commitment to integrating health and social care for people registered at the practice. The practice had also enabled the community nursing service to remain onsite and were fully integrated as part of the practice team.

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 offered proactive, personalised care to meet the needs of the older people in its population. All of the patients had a named GP and appointments were well co-ordinated to facilitate good continuity of care.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Initiatives such as the Blackdown Patient support group, provided services such as befriending to reduce the risk of social isolation on patients health and wellbeing. Patients were also able to access transport through this voluntary service to get to and from hospital appointments.

People with long term conditions

Outstanding

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

- Integrated health and social care is advocated by the practice and any potential barriers for patients to experience this are reduced.The practices had driven innovation by creating the role of practice community matron as a key point of contact so that there is greater anticipatory care of vulnerable patients and those with long term conditions.Data showed that the practice has reduced the number of unplanned admissions by a third in comparison to averages seen in the locality.
- All of the patients on the long term conditions registers had named GPs, who worked in conjunction with a GP buddy to provide an anticipatory and proactive service to support patients.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was higher than the national average. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 92.2%. (CCG 89.15% and 88.3% national averages).
- The practice followed the Exeter guidelines for management of patients with diabetes. A virtual clinic was held annually with a consultant providing clinical support for patients with complex

- health needs.Every quarter, a specialist diabetic clinic was held so that patients could be assessed and supported closer to home.This avoided them having to travel to Exeter for this service.
- Longer appointments and home visits were available when needed.

Families, children and young people

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

Outstanding

- 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, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 81.5%, which was higher than the CCG average of 77% and inline with the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

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

Outstanding

- 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 proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

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

- The co-location of the community nursing team and success of the in house long term conditions project meant that patients experienced well co-ordinated care and support. Data for the long term conditions project for 2014-15 showed that 43 patients were being supported with 292 patient contacts having taken place. Of these 21 patient contacts resulted in the prevention of an exacerbation of the patient's long term condition through early interventions. There were 40 patient contacts, which had facilitated patients being able to self-manage their condition.
- The practice offered longer appointments for any patients needing these, for example patients with a learning disability.
- The practice had scoped all support groups and organisations available in the rural isolated location and provided information for patients about these. Staff demonstrated they were able to access these in a timely way to support vulnerable patients.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Outstanding

People experiencing poor mental health (including people with dementia)

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

- 87.5% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 90.6%. This was above average compared with the clinical commissioning group (CCG) (87%) and national averages (88.5%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients living with dementia.

Outstanding

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. Two hundred and twenty two survey forms were distributed and 114 were returned. This represented about 1.5% of the practice's patient list.

- 96.47% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 93.1% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 97.4% of patients described the overall experience of this GP practice as good compared to the national average of 85%).
- 97.8% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards which were all positive about the standard of care received. These highlighted that the practice staff were compassionate, caring and proactive in providing support. In 20 comment cards, patients highlighted support for carers and vulnerable older people as being exemplary.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The results from the friends and families test were very positive. Out of 213 patient responses, 205 respondents said that they were likely or extremely likely to recommend the practice to their friends and family.

Care Quality Commission

The Blackdown Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Blackdown Practice

The Blackdown Practice is a dispensing practice and has one registered location providing general medical services at: The Surgery, Station Road, Hemyock, Cullompton, Devon EX15 3SF. There are two branch sugeries, both of which have dispensaries and are located at:

Churchinford - The Surgery Fairfield Green Churchinford Taunton Somerset TA3 7RR

Dunkeswell - The Surgery Culme Way Dunkeswell Honiton Devon EX14 4JP.

The Blackdown practice is situated in a rural area covering over 200 square miles. There are 7450 patients registered with the practice, who are all eligible to use the dispensary services. The majority of patients are of white British background. All of the patients have a named GP. There is much a higher proportion of older adults on the patient list compared with other practices in the area. Nearly half (45%) of the patient population are over 65 years, with a higher prevalence of chronic disease which the practice monitors. The total patient population falls within the low-range of social deprivation.

The practice is managed by five partners (three male and two female GPs).They are supported by a salaried retainer GP (female). The practice uses the same GP locums for continuity where ever possible. The nursing team consists of four female nurses; an independent nurse prescriber and three practice nurses. There are four female health care assistants. All the practice nurses specialise in certain areas of chronic disease and long term conditions management. The nurse practitioner is able to see patients with minor illness. All of the staff work across all three practice sites.

The Blackdown practice is a teaching and training practice, with three GP partners approved as GP trainers. Two GP partners are approved teachers with Health Education South West. The practice normally provides placements for trainee GPs. Teaching placements are sometimes provided for year 3, 4 and 5 medical students. One trainee GP was on placement when we inspected.

The Blackdown practice at Hemyock is open 8.30am to 6.30pm Monday to Friday. Phone lines are open during these times with patients directed to access the out of hours service via the 111 service outside of these times. GP appointment times are from 8.30am to 6pm every day. The branch surgeries are open every morning from 8.30am to 12.30pm every day, Churchinford branch surgery is open from 3:00pm on four afternoons a week, Dunkeswell is open for two afternoons a week from 3:00pm. The dispensaries at all three sites are open during the normal opening hours of the practice, except at at Hemyock which closed between 1pm to 2pm every day. Information about this was on the practice website and patient information leaflet.

Opening hours of the practice are in line with local agreements with the clinical commissioning group. Patients requiring a GP outside of normal working hours are advised to contact the out of hours service provided by Devon Doctors via 111. The practice closes for four half days a year for staff training and information about this is posted on the website.

The practice has a general medical services (GMS) contract.

Detailed findings

The following regulated activities are carried out at the practice: Treatment of disease, disorder or injury; Surgical procedures; Family planning; Diagnostic and screening procedures; Maternity and midwifery services.

On 30 June 2016, we inspected the Blackdown Practice in Hemyock, including the dispensary based there and at the two branch surgeries in Churchinford and Dunkeswell.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30 June 2016.

During our visit we:

- Spoke with a range of 14 staff (GPs, nurses, administrators, practice manager and dispensary staff) and spoke with five patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 22 comment cards where patients and members of the public shared their views and experiences of the service.
- Inspected all three dispensaries situated at the Blackdown Practice in Hemyock and the two branch surgeries in Churchinford and Dunkeswell.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us there was an open 'no blame' culture at the practice. They told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.The practice sent us a summary of 44 significant events, including complaints investigated over the last 12 months.We found that there was a learning culture at the practice, which led to a low threshold for reporting any events.Staff told us that the summary was a working document, which staff had access to and highlighted learning points for each event or concern received.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient had been seen sequentially on three different occasions by locum GPs with unexplained weight loss. The patient's records were reviewed and found that appropriate referrals had been made. However, the practice identified that there could be risks around continuity of care when locum GPs might not know patients as well as the patient's named GP. A system for managing patient results during periods of significant clinical absence was introduced to mitigate any potential risks to patient safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. All GPs were trained to child protection or child safeguarding level 3. Training information showed that practice nurses had completed child safeguarding level 2 training.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. Training records showed that all staff had been involved in a handwashing audit. Actions resulting from this identified that any temporary staff working at the practice needed to be included in these audits.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat

prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses was a qualified Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines).
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- We looked at the system for checking any locum GPs used for cover at the practice. Staff told us that the practice used regular locum GPs. All of the locum GP files contained information about their professional qualifications and working history in the form of a CV. The practice manager told us that checks were made of professional registers for all clinical staff, including locum GPs. We saw evidence of checks having been completed of the performers list held by NHS England and the General Medical Council

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had a health and safety committee comprising of representatives from all staff groups, including domestic staff.At this committee, risk assessments and actions taken were reviewed and ratified as being completed.An example seen was a risk assessment of the dispensary carried out at the branch surgery at Dunkeswell in September 2015.Actions and amendments had been agreed by the committee, including raising awareness of the lone working policy and having a minimum of two staff on duty when the practice was open.Dispensary staff at Dunkeswell Surgery confirmed that these actions had been completed and there were two staff on duty.
- The practice had fire risk assessments, which had been reviewed and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Electronic records were seen demonstrating that the practice had a rolling programme of maintenance for all equipment, including clinical equipment.We saw certificates showing that equipment was calibrated every year and was last done in June 2016.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. For example, the practice

had a GP buddy system which meant that patients were always able to see a GP who knew their needs. GP buddies were not allowed to be on annual leave at the same time.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice sent training information, which showed that all staff had received an update between April 2015 and March 2016.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. We saw that there was a system in place for named staff to carry out regular checks.Records seen, included the expiry date for all the emergency medicines which staff said provided prompts with which to be proactive with ordering replacements in good time.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2014/15 were 99.1% of the total number of points available.

We looked at exception reporting for patients diagnosed with osteoporosis where this was significantly higher at 33% when compared with the Clinical Commissioning Group or national averages (13% and 12.5%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice had a robust clinical led decision making system regarding exception reporting. The protocol outlined that patients would only be exempted from the review appointment, if all other avenues had been explored including being sent three prompt letters and being phoned by their GP to discuss this. The practice proactively managed any exception reporting. Data seen demonstrated that in 2014/15 the practice had exception reported six patients with osteoporosis and had reduced this to two in 2015/16.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the national average. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 92.2%. (CCG 89.2% and 88.3% national averages).
- Performance for mental health related indicators was better than the national average.For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 90.6%. This was above average compared with the CCG (87.2%) and national averages (88.5%).

The practice followed the Exeter guidelines for management of patients with diabetes. A virtual clinic was held annually with a consultant providing clinical support for patients with complex health needs. Every quarter, a specialist diabetic clinic was held so that patients could be assessed and avoid having to travel to Exeter for this service.

There was evidence of quality improvement including clinical audit.

- There had been 10 clinical audits undertaken in the last year, several of these were a completed audit where the improvements made were implemented and monitored. The practice had distributed a medicines alert about the associate risks to the unborn child of pregnant women prescribed valproate based medicines (mostly used to control epilepsy).The practice had also set up a pop up message providing cautionary advice about this every time a valproate based medicine was being prescribed by a GP. A completed audit found that none of the patients prescribed valproate were pregnant or within child bearing range in the first cycle.The audit had been repeated and identified a female patient with child bearing potential who then received additional counselling and advice about the associated risks of valproate during pregnancy and contraception.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result included: changing the monitoring system for uncollected prescriptions to increase patient safety and follow up where necessary.

Good

Are services effective?

(for example, treatment is effective)

Information about patients' outcomes was used to make improvements such as:

- The practice carried out a number of annual audits related to specific treatments.For example, in 2016 the practice audited the outcomes for patients being treated withanti-blood clotting medicine (warfarin).The audit found that out of 161 patients, 29 were in the therapeutic range less than 65% of the time. One of the actions taken by GPs was to review treatment with these patients and consider offering a new alternative anti blood clotting medicine. The benefit of this change in treatment for patients meant that their condition would be better controlled.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, nurses reviewing patients with long-term conditions had completed annual training updates covering diabetes, asthma and chronic pulmonary diseases.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. All of the nurses interviewed told us that all cervical screening results were reviewed and an audit carried out each year. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

The co-location of the community nursing team and success of the in house long term conditions project meant that patients experienced well co-ordinated care and support. Data for the long term conditions project for 2014-15 showed that 43 patients were being supported with 292 patient contacts having taken place. Of these 21 patient contacts resulted in the prevention of an exacerbation of the patient's long term condition through early interventions. There were 40 patient contacts, which had facilitated patients being able to self manage their condition.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

Good

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service such as the Healthy Living Centre, Memory Café, or Blackdown Support Group.
- Weight management support and smoking cessation advice was available from the practice nursing team plus a local support group.

The practice's uptake for the cervical screening programme was 81.5%, which was higher than the CCG average of 77% and inline with the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

A notice board in the waiting room provided patients with information about all the screening programmes available.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example, 76% of female patients in the eligible age range were screened for breast cancer, which was comparable to the CCG (77%) and national averages (72%). The percentage of patients in the eligible age range screened for bowel cancer was 60%, which was comparable with the CCG average of 61% and higher than the national average of 58%. We spoke with two male patients who told us they were eligible for aortic aneurysm screening and had this recently.

Childhood immunisation rates for the vaccines given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 80% to 98.2% and five year olds from 96.1% to 98%. (CCG ranges for child immunisation for under two year olds was 81% to 98.2% and five year olds from 91% to 96.7%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40 to 74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 22 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG) and two other patients. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The patients spoke about the compassion they had received from staff when they needed help and were provided prompt support when required.

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

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91.5% and the national average of 89%.
- 94.6% of patients said the GP gave them enough time compared to the CCG average of 90.2% and the national average of 87%).
- 98.2% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96.7% and the national average of 95%)
- 91.5% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- 91.4% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 97.9% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90.4% and the national average of 87%).

Care planning and involvement in decisions about care and treatment

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

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

- 95.6% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.8% and the national average of 86%.
- 91.8% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 91.4% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%)

All 27 patients who contributed verbally or in writing at the inspection confirmed that staff put them at the centre of their care and treatment. They told us that their wishes were always discussed and followed.

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

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

Are services caring?

- Information leaflets were available in easy read format.We saw the practice register for patients with learning disabilities, which enabled the team to plan ahead for reviews ensuring they would meet the specific needs of each patient.Staff shared examples with us about reasonable adjustments put in place to promote patients involvement in decisions about their health care needs. For example, a patient with communication needs had support from the learning disability nurse specialist at a screening appointment.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 250 patients as carers (3% of the practice list). There was a named member of staff who acted as the lead for carers. The practice was proactive in working with Devon Carers, which is a voluntary organisation. The practice facilitated the running of a monthly drop in clinic to provide advice and support for carers by providing accommodation and advertising this service to patients.

The practice had a strong communitarian approach. Three patients told us that a GPs at practice were founding members of a charity based within the building, which had been running for over 20 years. The charity was integral with services at the practice and provided additional voluntary services to support vulnerable patients who may be at risk of social isolation. We met the co-ordinator of this service who told us that over 300 patients and their carers received support from the charity each year. Written information was clearly displayed in the waiting areas directing carers to the various avenues of support available to them.

GPs were compassionate and closely managed the list of patients receiving palliative care at the end of their lives. GPs told us they aimed where ever possible to meet patients wishes about where they wanted to be cared for at the end of the their life. Five patients told us that GPs were responsive to these patients needs. This was illustrated by several examples, including delivering 'Just in case' medicines to a patient whose family were without transport and unable to collect these.

The practice had consulted with the Patient Participation Group about the support given to bereaved families. It was decided that the patient's usual GP would contact them and provide support as needed. 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.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. The practice is situated in a rural farming area which is some distance away from the main health and social care service centres. GP partners told us that a fundamental aim in developing services at the practice was to provide resilient, proactive and responsive services for patients there. We saw several examples demonstrating that patients experienced flexibility, choice and continuity of care. This was illustrated by:

- Nearly half (45%) of the patient population were over 65 years, with a higher prevalence of chronic disease which the practice monitors. This meant vulnerable patients could be at risk of unplanned admission to secondary services. The practice had obtained funding to create a practice community matron role, with the sole purpose of proactively managing patients who were vulnerable. In the four years since inception, over 40-50 patients received on-going support from this service at any one time. Data showed that practice performed well in managing patients with complex needs. There were fewer unplanned admissions for patients at the practice: the percentage of unplanned admissions per 1,000 patients for Blackdown Practice was 10.4% when compared with the CCG and national averages (CCG 14% and national 14.6%).
- The individual needs and preferences were central to the planning and delivery of tailored services. All 7450 had a named GP. The practice introduced a GP buddy system to promote patient continuity of care. There was an individualised approach to triage, where the patient's GP or GP buddy telephoned the patient and/or their carer where appropriate to discuss their needs. An agreed plan was then put in place, which could include an appointment being made or home visit arranged later the same day or alternative support being made available through the Blackdown Support Group (BSG). The BSG offered a number of services to support patients of all ages and was an invaluable service, particularly to those who were considered vulnerable or socially or geographically isolated.
- The involvement of other organisations and the local community was integral to how patients needs were met. Innovative approaches to providing person centred care involving other providers were evident at Blackdown practice. Examples included: collaboration and support of the only nearby adult social care provider to extend the service to include domiciliary care services in the area; promotion of healthy living through support of, and signposting patients to support services such as the local memory café.
- A flexible appointment system was in place, providing good patient access to telephone or face-to-face appointments and visits. This was illustrated by: operating as one virtual site providing good access across a large geographical area. The practice had a rota, which ensured that all three sites had GP cover every morning to allow those with limited transport arrangements to attend their nearest site and built in capacity for home visits to take place. All three sites were open on Monday afternoons and two doctors at each site, where ever possible every Friday morning.
- The practice offered Saturday morning appointments between 8am and 11am for all patients, which was beneficial for those working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- There was a proactive approach to understanding the needs of different groups of people, which delivered care in a way that met needs and promoted equality. Examples seen included: A member of staff was a dementia friend and current best practice was being disseminated across the practice to make services more accessible for people with dementia. Other reasonable adjustments were made and action was taken to

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

remove barriers when patients find it hard to use or access services, including level access throughout the building with wheelchairs easily accessible for patients needing these; Raised seating in the waiting room, for patients with poor mobility.

Access to the service

Blackdown practice at the Hemyock site was open 8.30am to 6.30pm Monday to Friday. Phone lines were open from 8.30am to 6pm, with the out of hours service picking up phone calls after this time. GP appointment times were from 8.30am to 6pm every day. The branch surgeries were open every morning from 8.30am to 12.30pm every day, Churchinford branch surgery was open from 3:00pm on four afternoons a week, Dunkeswell was open for two afternoons a week from 3:00pm. The dispensaries at all three sites were open during the normal opening hours of the practice, except at Hemyock which closed between 1pm to 2pm every day. Information about this was on the practice website and patient information leaflet.

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

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 86% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 96.5% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

The practice had a system in place to assess:

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

Five patients we spoke with verified that their named GP always telephoned them, if they contacted the practice with any concerns. They said that their GP discussed these concerns with them and then jointly agreed a plan with them. We observed GPs telephoning patients in between appointments and during the lunch period. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system Posters were displayed and a summary leaflet available for patients in the waiting room.

We looked at seven complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, the practice had used patient feedback about staff attitude and body language constructively. The feedback was used as a discussion point with staff to raise awareness of the impact of some behaviours and non verbal communication which could be perceived by a patient as being unfriendly and unwelcoming. During the inspection, we observed staff to be welcoming and friendly giving good eye contact with patients arriving at the practice.

Are services well-led?

Outstanding

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- Blackdown Practice aimed to provide patients with high quality integrated care and treatment through the promotion of good health and wellbeing. All staff demonstrated these values and were proud of their person centred approach. The practice constantly worked towards this vision reviewing how services were delivered at the practice through to secondary care services. GPs collaborated with other local practices to improve services for people in the area.
- The practice strategy and supporting objectives were stretching, challenging and innovative. There were several examples of this, including the approach taken in recognition of the link between social isolation and heightened health risks which had been prioritised for action. Innovative communitarian initiatives such as the Blackdown Support Group were providing much needed support where gaps in traditional services existed; the establishment of a dedicated practice community matron as a key co-ordinator supporting vulnerable patients was helping to reduce the number of unplanned hospital admissions.
- As a training practice, Blackdown Practice had attracted interest from previous trainee GPs interested in positions at the practice. Following the retirement of GPs, the practice had appointed two new GP partners, who were due to start in October 2016. which went against the national trend of difficulty to recruit GPs and the significant shortages of GPs.
- The Blackdown practice was collaborating with seven other practices to form a GP federation to work together to provide a greater range of services and also to share knowledge.
- The practice had secured funding for four years for a long term conditions project. This focussed on providing integrated health and social care for patients at risk in the community. The practice was also proactive in arguing for the community nursing team to continue to be based within the same building when this had been under review.Staff worked closely together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a quarterly basis when care plans were routinely reviewed and updated for patients with complex needs.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. There were named leads for all the patient registers, such as respiratory conditions, safeguarding, infection control and premises management.
- Leaders had an inspiring shared purpose and motivated staff to succeed. For example, there was a shared approach to all health and safety matters with representatives from all staff groups sitting on a committee which oversaw any risks, actions and ratified decisions made.
- Practice specific policies were implemented and were available to all staff. These were clearly dated, showing when the next review should be undertaken.
- A comprehensive understanding of the performance of the practice was maintained and minutes of meetings demonstrated this was discussed weekly. Discussions included, patient outcomes, learning from events and occurrences, audit outcomes, quality and performance data and access to the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice had a health and safety committee with representation across all staff groups. This promoted effective communication

and management of safety risks. Minutes of meetings held every quarter demonstrated that health and safety was given priority and actions taken to mitigate any evolving risks.

Leadership and culture

The partners and management team at the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. GPs in training and doctors on placement as part of their post qualification training had commented positively about the quality of support and education given.

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

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.
- The practice analysed trends and learning for all complaints received within a 12 month period. Dedicated time was made available for this to take place with representation from across the whole staff team so that any learning identified was shared and actions taken forward for improvement.

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

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. The practice closed for four half days per year in line with other practice in the area. This time was used to deliver staff training.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- Records showed that in March 2016, 111 patients were formally signed up to be part of the patient participation group, representing 1.5% of the practice population.
- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, in the previous 12 months the PPG had increased the ways in which news about developments at the practice and services available were published in the community. The PPG was also involved in creating a communications strategy for the practice.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff leading the long term conditions project had suggested that a survey should be conducted to obtain feedback from patients. In 2014, 27 patients sent responses with the majority rating the service as very good or excellent in supporting them. Staff told us they felt involved and engaged to improve how the practice was run.
- The Blackdown Practice provided placements for GPs, qualified doctors training to be GPs and students. The last deanery report was positive about the quality of training and support provided medical for trainees. We saw a certificate from Health Education England, which

Are services well-led?

Outstanding

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

had awarded the practice an excellent rating in 2015 for GP training. Feedback from trainees and students demonstrated this was a popular placement and they wanted to return to work there permanently.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The co-location of the community nursing team and success of the in house long term conditions project meant that patients experienced well co-ordinated care and support. The project provided an additional 12 hours of nursing intervention time to the practice nursing team. Data for the long term conditions project for 2014-15 showed that 43 patients were being supported with 292 patient contacts having taken place. Of these 21 patient contacts resulted in the prevention of an exacerbation of the patient's long term condition through early interventions. There were 40 patient contacts, which had facilitated patients being able to self manage their condition. Data showed that the practice had reduced the number of unplanned admissions by a third in comparison to averages seen in the locality.

The GP partners demonstrated a strong commitment to integrating health and social care for people registered at the practice. The practice had also enabled the community nursing service to remain onsite and were fully integrated as part of the practice team. This meant that through shared communication systems, expertise and access to training the practice had reduced any potential barriers for patients to experience integrated care.

The Blackdown Practice had close links with the universities as a teaching practice. Two GPs were approved GP trainers. There was a regular intake of GP registrars at the practice. Weekly educational meetings between the trainer and registrar/s took place. Registrants were also able to attend the partnership meetings at least once a month that were multidisciplinary in nature. These drew learning from practice data, national guidance and research papers which were then discussed and led to projects at the practice. The aim of this was to enhance patient care and treatment.