Cricketfield Surgery

Quality Report

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

Contents

Overall summary

Cricketfield Surgery is a GP practice providing primary care services for people in and around Newton Abbot, Devon. The team of eight GPs and one trainee GP provide medical care at the practice supported by nurses and administrative staff on weekdays from 8am. The practice closes at 6pm Wednesday to Friday. Alternate Mondays and every Tuesday appointments booked in advance are

Summary of findings

available from 6.30pm to 8.30pm. The phone lines open daily at 8:30am. Outside of these hours patients are advised to contact an Out of Hours service, which is delivered by another provider.

During our visit we spoke with 12 patients who were using the practice. Four GPs were working on the day of our visit and we spoke with three of them. We also spoke with two nurses, one health care assistant and seven administrative staff including the practice operations manager and the practice business manager.

The practice was supported with the continuity of patient care through established working relationships with other agencies and services. This included a local agreement for sharing of patient records, for example, between the practice and the local hospital.

There were several areas where improvements must be made in relation to the management of the practice. These related to assessing and monitoring quality of the service delivered and management of medicines and staff recruitment.

The practice had a higher proportion of older patients registered than the national average. Staff demonstrated competence in dealing with the health issues associated with old age. GPs had achieved the requirement for practices from April 2014, as part of the GP contract changes for 2014-2015, to ensure that each patient on their practice list aged 75 or over was assigned a named, accountable GP.

GPs and nurses provided routine appointments for the monitoring and treatment of patients with long term conditions. The practice provided family planning and maternity services such as post natal checks for mothers as well as children's immunisations. Midwifery services were provided by the community midwifery team, accessed through the practice. Young people were able to access sexual health screening, advice and support from the GPs and nurses. Health checks were offered to patients between 40 to 75 years of age. The practice had working relationships with mental health teams to enable continuity of care and support for patients of all ages who may have mental ill health.

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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 ensured patients were safe but some improvements were needed.

Systems were in place which recognised and supported patients who were at risk of significant harm. However, training about safeguarding children and safeguarding vulnerable adults had not been carried out consistently at required levels to ensure that all GPs and staff knew how to respond if they suspected a child or an adult was at risk or had experienced harm.

The practice had systems in place to monitor that vaccines stored at the practice were safe and had been stored at the correct temperature. However, there were some anomalies when the temperature was outside the recognised safe range that had not been acted upon. This put patients at risk due to the incorrect storage temperatures of vaccines being maintained.

Patient safety was compromised by lack of attention to maintaining systems supporting the work of the practice. For example, emergency medicines and single use equipment had passed their expiry date, cover for absence of staff responsible for checking emergency medicines and signage for all storage of oxygen were not provided.

Are services effective?

The practice was effective but some improvements were needed.

Clinical staff demonstrated how they had ready access to national guidelines and protocols for many long term conditions.

The practice had introduced changes to improve staff recognition and response to children presenting with potentially critical illness.

There were a number of areas where the practice was not able to demonstrate effective systems were in place to ensure patients benefited from timely interventions. For example, the system of recall for blood tests and the system for review or change to repeat prescriptions were open to risk of delay if the patient's GP was absent. The system for review of patients in contact with the out of hours service by a practice GP was open to risk because the practice did not have a clinical overview of all out of hours notifications it received. The referral process was incomplete as the practice did not

Summary of findings

have a system in place to follow up on patients alerted to them who had failed to make an initial hospital appointment. The practice did not have a system in place to allow for auditing of medical safety alerts or mapping the actions by GPs and nurses following the alerts.

The practice was not able to demonstrate a system was in place for managing and monitoring significant events unless they were about medicines and or prescribing, or any systems to demonstrate learning outcomes from serious incidents.

Are services caring?

The practice was caring.

Patients were involved in decisions about their treatment. They were confident about talking with their GP and having their concerns heard. Patients told us they were treated with kindness, dignity and respect.

Patients' privacy was respected and information about them was handled with respect for their confidentiality.

Are services responsive to people's needs?

The practice was responsive but some improvements were needed.

The practice offered a range of treatments, screening and preventative measures to respond to patients' health care needs.

The practice was reviewing how patients accessed appointments to ensure it was in a way that benefited patients.

The practice was unable to demonstrate it had systems in place for patients to feedback, or that there had been discussion with other health care professionals about how to improve its services. The practice was also unable to demonstrate there was a system in place for analysing and learning from complaints, or any training needs identified.

Are services well-led?

The practice was not well-led.

The practice was undergoing a lot of change. Systems and processes were fragmented across several areas with little to demonstrate regular assessment and monitoring of the quality of services the practice provided.

There was a recognition there needed to be improved communication between all the staff groups and GPs.

The practice was not able to demonstrate it had effective systems in place to show it was responsive to patient feedback.

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

The practice identified its patient population of older patients as higher than the UK average. This included approximately 180 older patients residing in care homes. One GP specialised in care for older people and was working with the clinical commissioning group (CCG) to set up named practices for named care homes. Two other GPs provided ward rounds at two local care homes. Patients over 65 years of age had been informed of their named GP at the practice.

Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. Older patients could be referred to local services such as dementia screening clinics and falls assessment clinics.

GPs had open contact with the older persons mental health team should they need to seek advice. If an older patient was already known to the team, GPs could contact the community psychiatric nurses (CPNs) directly.

The practice was mindful of patients' healthcare expectations and their ability to access resources at the practice more easily than a local hospital.

People with long term conditions

The practice cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. They received telephone call backs and follow ups if they missed appointments. Medicines were regularly reviewed to ensure they were appropriate and beneficial to the patient.

The nurses worked to the National Institute of Health and Care Excellence NICE guidelines for Chronic Obstructive Pulmonary Disease (COPD) and diabetes. The practice had two lead GPs for diabetes.

Families, children and young people

The practice had a high proportion of young families. The GPs provided family planning. A midwife provided weekly clinics and nurses provided child immunisations. There was a clear follow up process for missed appointments. There was also a clear process for staff to follow if an immunisation was refused and if another relative/carer brought a child to their appointment.

Summary of findings

The practice offered sexual health support and information for patients less than 25 years of age. Screening of young people for Chlamydia was provided by the practice. GPs were able to refer patients to a local sexual health clinic for advice and support with sexually transmitted diseases. There was a noticeboard with information specific to young people.

Working age people (including those recently retired and students)

The practice had a semi-rural patient population and it was not situated in an affluent area. Many people travelled out of Newton Abbot to go to work. The practice offered longer opening hours one evening a week and one additional evening alternate weeks to accommodate working patients' needs outside working hours.

Health checks were offered to patients aged between 40 and 75 years of age, 100 letters a month were sent out to invite patients for a health check and staff confirmed there was a good response. There was a clear audit trail to show when a GP needed to follow up from a health check.

People whose circumstances may make them vulnerable

The practice had a small number of patients with a learning disability. The nurses were able to request support from specialist learning disability nurses if needed. There were no specific aids such as pictures to assist with communication and visual signage around the practice was limited.

The practice had linked up with a local charity and had access to toiletries and food boxes that could be given to anyone as necessary.

Patients with no fixed address were able to register with the practice.

The practice had a small number of patients who did not communicate in English. These patients attended appointments with a family member who provided translation for them.

There was a flag system on patient records to show those patients including children who were considered by the practice to be at risk of harm. The practice also held a list of all children who were patients and on the child protection register with a record of family relationships on the patient record.

People experiencing poor mental health (including people with dementia)

Patients experiencing poor mental health were involved in decisions about their treatment. If they lacked capacity other health care professionals were involved in decisions on behalf of the patient.

Summary of findings

As part of checks for quality prescribing, reviews were undertaken by the practice to identify if the mental health team had been involved in the decision (or oversight) of each patient's prescription. If this was not the case, this was referred to the patient's usual GP for action. Usually this involved the GP visiting the patient and or discussion, where appropriate, with other health care professionals and care home staff to determine the suitability or otherwise of on-going treatment.

Summary of findings

What people who use the service say

We spoke with 12 patients and received two comments cards completed by patients. Patients rated the practice and its staff highly. Patients who had been with the practice for many years said staff knew their medical history and they felt safe. Patients told us they were given the right medicines for their conditions, they knew what their medicines were for and it was reviewed regularly. Those with complex or long-term conditions said communication between hospital consultants and the practice was good and GPs were prompt in follow-up appointments.

Some patients reported mix-ups with repeat prescriptions. A receptionist showed us that on some repeat prescriptions it stated that items may go onto two pages. This could be missed and the reception staff prompted patients to check both pages.

Patients told us about the difficulties they experienced when making an appointment. They were not clear about the ways in which they could make an appointment, for example, they could book appointments via the practice website. This resulted in patients ringing the practice at 8.30am to ask for a same-day or emergency appointment. Patients told us they found it difficult to get through on the telephone because all the lines were busy and when they did get a response all the appointments were usually taken.

Patients expressed frustration about a general lack of communication. For example, patient suggestions included that the practice website could be better utilised and patients encouraged to book appointments online instead of by telephone.

The practice operations manager told us that systems were in place to meet the demand for appointments and there were options on the practice answerphone message. The GP for the day saw patients needing urgent appointments. There was a telephone triage system and most patients we spoke with were happy with the opportunity to speak with a GP on the telephone.

Some patients told us the receptionists asked for some details about the reason for an appointment. We found a number of patients objected to these questions because they did not think it was appropriate. The practice manager explained the questions had been introduced as a means to signpost to the GP, nurse, or GP's telephone call.

Areas for improvement

Action the service MUST take to improve

The recruitment and selection process for staff must be effective with full and relevant checks required for all staff prior to commencing work in the practice. If a particular job role is deemed not to require a criminal record check there must be a risk assessment to show why this is the case.

The practice must have systems in place to

- enable patients to give feedback
- manage and monitor all significant events and demonstrate learning outcomes from serious incidents.
- audit medical safety alerts or pathway of actions by GPs and nurses from the alerts.
- follow up on patients alerted to them who had failed to make an initial hospital appointment.
- review patients in contact with the Out of Hours service, to obtain a clinical overview of the patient.
- monitor and overview of staff training

The practice must have clear procedures for staff to follow to ensure safe storage and monitoring of vaccines or to ensure medicines and equipment required for resuscitation and other medical emergencies are maintained in date. Staff must be clear about reporting processes and action to be taken, if refrigerator temperature recordings show any anomalies. Patient safety must not be compromised by lack of attention to, for example, checking dates of expiry on emergency medicines and equipment, and misleading signage for the storage of oxygen.

Summary of findings

The practice must regularly assess and monitor the quality of services it provides, and analyse and learn from complaints.

Cricketfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor, a practice manager specialist advisor, an expert by experience (this is a person who has personal experience of using or caring for someone who uses this type of care service) and a second CQC inspector.

Background to Cricketfield Surgery

Cricketfield Surgery provides care and treatment to approximately 10,500 patients. It is located in the town centre of Newton Abbot however provides services to patients living across a semi-rural area. There are five partners, three salaried GPs and one trainee GP. All the GPs except one are part time and each work an average of six sessions with additional sessions to cover sickness and other absence. The practice is a teaching practice and provides placements for medical students from Year 1 to Year 5. It is also signed up to become a research practice in 2015. There are three practice nurses and four healthcare assistants. A nurse practitioner vacancy is temporarily covered by a salaried GP working four additional sessions. Reception and administration staff are trained to work in reception and administration roles. They rotate between jobs to ensure all areas are covered by permanent staff.

The practice provides services from Cricketfield Road, Newton Abbot, Devon TQ12 2AS where we carried out an announced inspection on 17 July 2014.

Out of hours services are provided by another organisation.

The practice does not have an active patient participation group (PPG). This is a group that would act as a voice for patients at the practice.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before the inspection site visit we reviewed a range of information that we had about the service. This included information shared with us by other organisations such as the local Healthwatch, NHS England and the clinical commissioning group.

We carried out an announced inspection visit on 17July 2014 at Cricketfield Surgery, Newton Abbot, Devon TQ12 2AS. We spoke with three GP partners, three nursing staff, five reception staff, the practice operations manager and the practice business manager who were all working on the day of our visit. We looked at the arrangements in place for patients for monitoring their presenting symptoms, diagnosis and treatment. We observed how the service handled telephone calls and patients arriving at the practice. We spoke with patients, other carers and or family members. We reviewed two comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

Significant events were considered by the GPs to identify whether it was a single isolated incident or something more endemic. Any major clinical concern was referred to the NHS area team. The clinical commissioning group (CCG) was advised of any service failure that may affect patient safety.

Learning and improvement from safety incidents

The GPs told us the practice had a system in place for reporting and recording significant events. Serious issues with prescribing and medicines management were treated as significant events. We were given an example of change to prevent prescribing and dispensing errors for opiate home treatment medicines. (These were issued to cover deterioration/worsening symptoms for patients with a terminal illness.) If the prescription for the items was not specified to the pharmacist's satisfaction, the items were not dispensed. Pre-dosed instructions were available to be added to the printed prescription to ensure the requirements for prescribing controlled drugs were consistently met by the practice.

A system was in place for managing and monitoring significant events about medicines management or prescribing. There was a book in reception and another one in the administration room for recording incidents. Staff were unsure when this system started. A few incidents had been recorded since May 2014. There was no evidence to show what had been done about the incidents, what had been learnt or what had been changed. There were no minutes from meetings to show that these incidents were recorded or acknowledged.

Reliable safety systems and processes including safeguarding

The practice had a chaperone policy which was accessible to all members of staff. A chaperone is a person who accompanies a patient during examination or treatment, Chaperones may also be used during consultations with vulnerable adults and of children. The practice policy was for a healthcare professional (usually a nurse) to provide the chaperone role as they had undergone the required criminal records check.

The practice had designated lead GPs for safeguarding children and safeguarding vulnerable adults. A monthly multi-disciplinary meeting was held which included safeguarding concerns about children. At the time of our visit 41 children were recorded on the children at risk register. GPs and administration staff were able to add family relationships to patient records and identify where there were concerns. The GP safeguarding lead for children had completed level three training in the past and was in the process of updating this. We saw evidence showing safeguarding children level two had been updated in March 2014. We spoke with a health care assistant (HCA), two nurses and five administration/reception staff about their knowledge of safeguarding. They demonstrated knowledge of safeguarding and how to recognise abuse. They cited examples of withdrawn vulnerable adults or bruising in children or inappropriate behaviour in the waiting room. They were able to describe how they might identify concerns and who they would report to internally. Any safeguarding issue would be raised with either of the two clinical leads or in their absence either of the two managers.

A GP told us that a child protection folder with guidance for staff was available and accessible to all staff in the reception area. There were no posters or information in reception or the nurses' rooms for reporting possible abuse. One nurse knew the local multi agency safeguarding hub or safeguarding vulnerable adults team could be contacted, but not contact numbers. The other staff were not sure about the channel of escalating abuse to appropriate health or social care professionals outside the practice. These staff also confirmed they were aware of whistleblowing and what it was, but not of a practice policy.

The practice managers told us there was no training log or record in which details of safeguarding training was kept. They said this would be kept by the GPs on their own files for appraisal. The practice operations manager was later able to provide information that showed a small proportion of GPs had completed safeguarding children training below level three, and a minority of GPs had completed safeguarding vulnerable adult training.

Monitoring Safety & Responding to Risk

Monthly meetings were held with the multi-disciplinary team. This included district nurses, mental health nurses, health visitors and community matron. Vulnerable patients were discussed ensuring a plan of care was arranged.

Are services safe?

A GP was responsible for ensuring all the GPs and nurses received any medical alert warnings or notifications about safety. Nurses attended required study days to ensure their knowledge was up to date, for example, about care of patients with diabetes. All staff had access to online training. We saw evidence of updates for nurses and certificates for core training in staff files.

Staff could enter alerts on patient records such as a child at risk or a medical alert advising a patient could be aggressive or violent towards staff.

All staff had access to an alarm in the event of an emergency to alert either all staff or only GPs and nurses depending on the nature of the emergency.

Medicines Management

The practice had identified a GP lead with responsibility for medicines management. It also had a prescribing administrator. Historically this role was funded by the previous commissioners however the practice had retained the role due to its perceived value. The administrator provided a portal for concerns. Anything urgent was dealt with by the duty GP. If it was a minor issue, feedback was given to the prescriber. Serious issues were managed through the significant event process. and also discussed at the monthly clinical meeting held with the GPs and nurses. The significant event process would define both where the issue occurred in the pathway leading to the dispensing of the item and how the practice would report this to the patient.

There were systems in place to monitor that vaccines stored at the practice were safe and had been stored at the correct temperature. However when anomalies in temperature range were recorded to show it was outside the safe temperature range, this was not always acted upon. For example, we looked at the temperature check book for the refrigerator located in the ground floor waiting area to see that an acceptable range between two to eight degrees Celsius (C) was maintained. Daily checks had been done but on the two days preceding our visit the refrigerator temperature had reached its maximum and was outside this range (10 – 11 degrees C). No immediate action had been taken to report this or to isolate the affected vaccines to prevent accidental use. The practice operations manager was unaware of the temperature rise. The temperature was within the appropriate range at the time of inspection.

We were advised the waiting area was the only space available to store the refrigerator. We noted it would not be accidentally disconnected as it was plugged into a socket behind the refrigerator. There was also very large notice advising that the refrigerator must not be disconnected.

We checked some medicines from different parts of the refrigerator for expiry dates and found these were all in date. Some emergency medicines were out of date so may not have been effective in an emergency, however they had been reordered in early June before the expiry date at end of June. It was not clear why this was not followed up. We also found with the emergency medicines and equipment, a catheter for suction and face masks were out of date and needed replacing. These had been ordered. The practice had a statement to formally record the practice's facilities and this included that emergency medicines and equipment were checked monthly for the maintenance and adequate supply, and to ensure items were in date.

The practice had oxygen on the premises. Although there was appropriate Health and Safety Executive (HSE) signage for some oxygen cylinders, this was not in all areas where they were stored. In the event of a fire this signage could be misleading thereby compromising safety of patients and staff in the practice.

The practice held regular meetings with the CCG prescribing team who made some positive comments about antibiotic prescribing.

Cleanliness & Infection Control

Patients said the practice was always clean. The provider had an infection control policy and a dedicated infection control lead who attended up to date training. Staff explained the daily infection control procedures which included checking sufficient equipment was available.

The clinical rooms were stocked with personal protective equipment (PPE). This included a range of disposable gloves, clinical cleaning wipes, aprons and coverings, which we saw staff used. This reduced the risk of cross infection between patients. We saw antibacterial gel was available in the reception area for patients to use upon entering the practice.

There were cleaning schedules in place and an infection control audit system was in operation. Staff were clear about their responsibilities in relation to infection control. For example, all staff knew who the lead for infection control was, knew where to find policies and procedures

and were aware of good practice guidance. The treatment and consulting rooms looked clean however some were cluttered. Consultation rooms were carpeted. We noted one consultation room had stains on the carpet. Treatment rooms had hard flooring to simplify the clearance of spillages.

The practice out-sourced the sterilising of re-usable instruments needed for clinical examination, tests and minor operations. Some disposable single-use instruments were used as supplements when needed.

The staff told us they had received updated training in infection control and this was repeated annually.

Staffing & Recruitment

We reviewed seven staff folders. Most contained contracts and certificates however some information was missing. This included no record of nursing and midwifery council (NMC) registration for one nurse, no evidence of qualification for two nurses and no information to cover gaps when not employed by the practice. Four staff files for administration and reception staff had no evidence of a risk assessment to show when a criminal record check was not needed and only one had a reference. The practice operations manager informed us that most of the staff were known to the practice and this might explain absence of references and risk assessments.

A member of staff described the recruitment procedure, confirming that an interview was conducted by the two practice managers and induction had been with other members of staff. The practice business manager was responsible for all GP recruitment. There was no system in place to routinely check GP registrations with the general medical council (GMC) to ensure they were up to date, however, a sample of five GP files showed they all held complete paperwork including medical indemnity cover and up to date registrations.

Dealing with Emergencies

There was an emergency incident procedure to support staff if they encountered violent or aggressive patients either at the practice or over the telephone. In the event that a patient's behaviour escalated to become verbally abusive or violent towards staff, a letter was sent giving the patient clear boundaries of what was acceptable behaviour and steps that would be taken by the practice.

There was a flowchart for staff to follow if a patient was having a heart attack. There was also an escalation procedure for sick children who may potentially be very sick needing hospital treatment.

The practice had a traffic light system in place to highlight when an extra GP would be needed. If GP cover fell below the practice's expectation, then a locum was booked. We were told that locums were a limited resource in this area of the country so needed to be booked in advance and for longer periods. Locums were generally booked to cover holiday periods and GPs offered additional sessions to cover sickness or unplanned leave of a colleague.

Equipment

The practice had a medical devices maintenance and central sterile supplies contract with a local hospital and an on-line record of recent return of equipment to the practice after calibration.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

GPs and nursing staff demonstrated how they had ready access to national guidance in their consultation and treatment rooms, for example there were national guidelines and protocols available for many long term conditions. The minutes of clinical governance meetings showed that safety alerts and new guidance were discussed.

Management, monitoring and improving outcomes for people

Prescriptions due for review or requiring a change were managed usually by the GP who had initiated the medicine(s). If a review or change was required on days the initiating GP was not working, these were not allocated to another GP, so patients had to wait for a new prescription to be issued.

The practice had changed its policy so anticoagulant tablets (a medicine to help reduce the ability of the blood to clot) was not added to repeat prescriptions until patient blood tests showed that dosing and blood clotting times were stable. Additionally to ensure more accurate and safer dosage, when the community nurses took blood for monitoring, a record of what dose the patient was actually taking at the time of the blood sampling was required in case this had changed since the last record made. Any medicine change was noted too.

An audit of patients with atrial fibrillation (irregular heart beat) had identified those whose test results may be frequently out of the therapeutic range. The outcome of this audit suggested that these patients may be better managed on different anti-coagulants which had prompted individual patient reviews.

The practice had introduced changes to improve staff recognition and response to children presenting with potentially critical illness. For example all staff, GPs and nurses had ready access to criteria on the practice intranet and flowcharts for a sick child developing into a potentially very sick child requiring hospital.

In the event of a medical alert, patient records were searched to identify patients affected by the alert. Lists of patients were then provided to each named GP for action as appropriate. We found the practice did not have a system in place for recording the management of alerts. There was no auditing of the alerts or mapping the journey of actions taken in response to the alerts.

Effective staffing, equipment and facilities

The induction policy described a structured process. We saw evidence of an induction timetable for one new member of staff dated 24 April 2014 with a review after six weeks. However, there was no evidence of this review. The practice operations manager informed us that it had been carried out informally and that usually if there were no problems, staff carried on working and were reviewed informally.

The practice operations manager carried out annual staff appraisals for all administration and reception staff including developing personal development plans (PDPs). Training was provided about information governance, safeguarding vulnerable adults and children, risk assessments and confidentiality. Fire safety training was mandatory for all staff and GPs.

The practice had a risk assessment and preventative measures in place to ensure the safety of the premises. A contractor was responsible for all health and safety checks and utilities. We saw records of comprehensive, up to date checks, including water and electricity.

Staff had access to a panic alarm system that linked to all rooms to alert other colleagues of an emergency requiring intervention and assistance.

Working with other services

Blood results received at the practice were assigned to a GP. If the practice operations manager could not resolve which GP had referred the patient for blood tests, the results would be referred back to the pathology laboratory. The pathology laboratory usually telephoned the practice to highlight any seriously abnormal blood results. GPs checked their pathology results daily and if they were on leave they had a buddy system in place. However there was no system in place for less serious results to be prioritised for review if it was the referring GP's non-working day/ absent for the day.

The multi-disciplinary meeting had care plans in place for vulnerable older patients. For those patients living in care

Are services effective?

(for example, treatment is effective)

homes there were treatment escalation plans including information about resuscitation decisions. For the out of hours service, there was a separate message in the care document and a GP could add free text to this if needed.

Updates about any patients seen by the Out of Hours service were sent to the practice. The practice operations manager sifted these updates to identify which patients needed a GP review. The updates deemed to not require a GP review were scanned by the administration staff and added to the patient's notes. This decision was not taken by a GP. There was a lack of clarity about the criteria for the division of patient contacts into those to which the practice GP was alerted and those not so.

GPs used the "choose and book" referral system. This is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. "Choose and book" alerted the practice if a patient failed to make an appointment. There was however no process in place at the practice to follow up with patients about this.

Locality meetings for all the practices in the South Devon and Torbay Clinical Commission Group (CCG) area, run by the CCG, were held regularly. These alternated between practice manager only meetings and joint meetings with practice managers and GP representation from each practice. Referral data was discussed at these meetings as well as much wider issues such as funding and other issues affecting local practices. One outcome from these meetings was a local agreement that had been set up for information sharing about patients between services and practices. For example, if a patient was admitted to the local community hospital, the community hospital GP lead could view but not add to the practice patient record. This provided a full audit trail of the patient's journey. Another outcome from these meetings was raising the profile of health visitors and their availability to practices.

Health Promotion & Prevention

There were plenty of leaflets available for patients on racks and on tables. There were separate noticeboards with information for carers and for young people under 25 years.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients were seen in separate and private rooms by GPs and nurses. Patients said they were happy with all of the staff including the reception staff. Patients told us the receptionists were polite and friendly and they were treated with respect by all the staff. Patients described all the GPs positively. We observed receptionists dealing with patients on the telephone and in person. They appeared polite, respectful and sensitive to patients' needs.

Patients were able to speak to staff in private however they had to request this as there was no mechanism to offer this proactively. The reception counter was designed in such a way that patients could speak to staff with a degree of privacy. Usually one member of staff was responsible for the reception front desk, and other reception staff handled phone calls from a back office and administration room. Confidentiality was not assured if voices were raised.

Involvement in decisions and consent

Patients said they had felt involved in planning and decisions about their treatment and care. We asked whether they had been given choices of treatment, and whether any options had been explained. Where applicable patients considered they had been thoroughly involved all through their treatment. Not everyone felt they had been fully informed about treatment options, but some recalled having been given written information by staff.

Patients praised the organisation of clinics such as flu vaccinations. Patients told us how well they were treated regardless of age. Parents were satisfied that their concerns about their children's health were taken seriously and their GP listened to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

Practice staff cared for patients with long term conditions including asthma, diabetes, and heart disease. They also provided child immunisation, travel vaccinations and phlebotomy (the process of taking blood). Maternity services were provided by the GPs and a midwife held a weekly clinic at the practice.

At the time of our visit the practice offered appointments with GPs between 8.30am and 11.30am, 2.30pm until 6.30pm and one evening each week, on alternate weeks there was an additional evening surgery until 8.30pm. Nurse and healthcare assistant clinics started at 8am. These clinics and appointments with the duty doctor continued into the lunchtime period. The other GPs carried out home visits during the lunchtime period.

Access to the service

Patients' biggest concern was about the availability of appointments. They felt the GPs did not know how difficult it was to get an appointment, particularly if it was an unplanned follow up with the same GP. They said that unless they could be ready and telephone at 8.30am they could not get an appointment on the day they wanted it. They also said the telephone lines were very busy at that time. We heard examples of older patients who needed to drive to their appointments and found it very difficult to be up and ready by 8.30am to telephone the practice, and follow-up appointments being made for 8am which caused further difficulty. Younger patients told us similar stories about the impracticality of telephoning at 8.30am because they were either going to work or getting children to school. Patients we spoke with did not have a clear understanding of how they could make an appointment and the majority thought they could only call the practice at 8.30am.

A receptionist said most complaints were about the difficulty in getting appointments. Patients wanted to be able to book for a few days ahead but usually all appointments that could be booked ahead were filled over a week in advance. Many of these were filled by GPs booking follow up appointments for their patients. If patients telephoned on the day, they could see a duty GP or if they preferred, the duty GP would telephone them.

Patients confirmed they had received call-backs when requested and they were satisfied with the opportunity to speak with a GP on the telephone.

Patients who visited the practice regularly and whose GPs made their follow-up appointments had no difficulty with the system. They said they could usually see the GP of their choice. There was no information available about when a particular GP would be available so patients did not know until they called the practice whether or not their GP was available.

The practice operations manager told us patients were able to book appointments up to four weeks in advance however, the receptionists thought this was two weeks.

We received additional complaints about the telephone system which some patients found very daunting having to select an option before they could speak with a member of staff. Some patients objected to the receptionists asking for some details about the reason for an appointment because they did not think it was appropriate. The practice had introduced this as a means to signpost to the relevant staff. The receptionists were also able to add brief notes to the patient's record to provide the GP or nurse with a quick overview of the patient's reason for requesting an appointment. These notes could include if the patient needed an urgent call-back.

Patients said they were happy with waiting times once they were at the practice. Sometimes they had to wait up to thirty minutes but as long as they then had the time they needed with the GP they did not mind. On the day of our visit that a few patients were waiting for this length of time but most were seen sooner.

Meeting people's needs

Conversations with reception staff were private unless patients had hearing difficulties and reception staff raised their voices to make themselves heard.

Accessibility to the ground floor was good. The practice had a ramped entry, an accessible toilet, level ground floor and a chairlift. There was a sign at wheelchair height at reception advising patients with a range of difficulties such as, visual, hearing, physical, to ask at reception for help. A receptionist said the most common query was for assistance with opening the toilet doors as patients needed a code.

Are services responsive to people's needs?

(for example, to feedback?)

There were few avenues for patients to be listened to or to suggest improvements. The website was very limited in relation to receiving feedback and there were no forms or meetings for patients to contribute their ideas.

Concerns & Complaints

The practice had a process for recording complaints and significant events. There were 15 complaints recorded during 2013/2014. The practice operations manager told us that verbal complaints were recorded in patients' records. We were unable to verify this as neither of the practice managers were able to provide an example of a complaint recorded this way. Written complaints and incidents were discussed at the GPs weekly meeting. Any action points were recorded. The staff told us they tried to give a high level response early on, as a way of reducing complaints. We reviewed five responses of the 15 written complaints received. None of these provided information for patients about how to take their complaint further if they were not satisfied with the outcome of the practice investigation of their complaint.

The practice had a complaints policy however this was out of date. For example, elements of the policy were no longer relevant as it referred to an organisation no longer in operation. There was no information in the waiting room or on the practice website providing information about to how to make a complaint. The receptionists and practice operations manager explained that patients were asked to approach reception staff to make a complaint and the issues were usually dealt with there and then. This limited the practice's ability to audit their complaints and identify themes in order to develop action plans or identify training needs.

Are services well-led?

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

Our findings

Leadership & Culture

Systems were fragmented across several areas. The practice was not able to demonstrate it had effective processes in place to show it was responsive to patient needs.

The practice had a pool of GPs that they used as locums. These GPs could be called upon at short notice in an emergency. It was unusual for the practice to require the use of temporary reception and administration staff as they all tended to cover each other. The practice had also used staff from local practices in the past. We saw evidence of a locum pack which provided details of immediately necessary information locums might require during their work at the practice. This pack had been updated in September 2013.

The practice had a system in place for taking up references, checking CRBs and other checks for GPs who requested locum work. When a locum was employed, their performance was reviewed and if unacceptable, the practice stopped using them. We reviewed four folders of locum GPs, one of which had a note dated March 2013 for this GP not to be used again. The practice did not hold itself accountable to put in place a system to notify the NHS England Local Area Team as well as local GP practices of this fact which, if significant or a clinical issue, could put patient safety at risk.

Governance Arrangements

The GPs met together informally for up to half an hour on most days. This provided an opportunity to discuss case management and what services were available. It was also a valued interaction for those GPs who worked part time at the practice. They also all met formally once a week. The practice managers were not represented at all the partner meetings and no-one took responsibility to take things forward and the salaried GPs did not attend these meetings at all. Several other meetings were held between different staff teams about a variety of subjects for clinical, practice and business matters. Minutes were kept of some but not all meetings. The practice managers told us that the practice was undergoing a lot of change so meetings were evolving and communication and ways of working were changing. They had recognised there needed to be improved communication between all the staff groups and GPs. To address some of the concerns the practice had introduced an actions log to ensure things were followed up and structures were being built in to ensure practice issues and business matters were discussed, working towards decision making about the future delivery of the service.

Systems to monitor and improve quality & improvement (leadership)

A series of audits had been accomplished, action had been taken in response and further audits planned or carried out to complete the cycle. However, there was a lack of completion of the quality assurance circle. For example, action had been taken on significant events but there was no analysis or record of sharing. Similarly not all audits were completed or showed a record of sharing.

Policies were in place but there was not system for periodic review to ensure they were up-dated in accordance with current guidelines. We did not see an overall quality improvement plan. However, the practice business manager told us about a business plan to map the way forward.

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

The patient participation group (PPG) at the practice had disbanded and there were no formal plans to reform a group. The practice business manager acknowledged that the practice needed to review how to set up a new PPG. A patient survey undertaken in the Spring had asked patients if they would be interested in joining a PPG but there had been little take up.

The practice had an annual patient feedback survey. The most recent one had been modified to include additional services offered by the practice such as online repeat prescription requests. As a result of feedback in a previous patient survey, additional appointments had been made to accommodate working patients.

There were few avenues for patients to be listened to or to suggest improvements. The website was limited in relation to obtaining feedback and there were no forms or meetings for patients to contribute their ideas.

Management lead through learning & improvement

All the GPs had internal and external networks of support and appraisal. They met annually with other GPs who were recognised appraisers. (A GP appraiser is responsible for seeking assurance about a GP's level of engagement with

Are services well-led?

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

relevant learning activities to support continuing professional development and best practice. They are external to the practice.) The GPs maintained a record of evidence kept for the appraisal to show details of their continual professional development, this included study days and individual learning. All the GP partners also received an in-house appraisal from another partner in the practice. This was a management review and feedback about clinical management.

Nurses had personal training records and told us they had good opportunities to further their training. The health care assistant was undertaking training about dressings and electrocardiogram (ECG) recording. Nurses had access to national guidance and protocols, and safety alerts and new guidance were discussed at clinical governance meetings.

Administrative staff and reception staff had completed mandatory training such as cardiopulmonary resuscitation (CPR), fire safety and information governance covering confidentiality and data protection.

Identification & Management of Risk

The practice did not have a procedure to manage incident reporting. There was an incident book on each floor for staff to record incidents. These were initialled to show they had been reviewed by one of the practice managers however there was no consistency in checking these books. The practice was not able to demonstrate any analysis or discussion of learning points or show that any action had been taken to change practice or identify learning needs to minimise risks.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The practice did not have systems in place to regularly assess and monitor the quality of services it provided. Systems of recall for blood tests and review of repeat prescriptions did not ensure these were not missed or delayed if the patient's GP was absent for reasons other than holiday or sickness. The system for review of patients in contact with the out of hours service by a practice GP was open to risk because the practice did not have a clinical overview of all out of hours notifications it received. The referral process was incomplete as the practice did not have a system in place to follow up on patients alerted to them who had failed to make an initial hospital appointment. The practice did not have a system in place to allow for auditing of medical safety alerts or mapping the journey of actions by GPs and nurses from the alerts. The practice was not able to demonstrate a system was in place for managing and monitoring significant events that were not about medicines and or prescribing, or any systems to demonstrate learning outcomes from serious incidents. The practice was unable to demonstrate it had systems in place for patients to feedback or discussion with other health care professionals about how to improve its services.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Compliance actions

Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	The practice did not have clear procedures for staff to follow to ensure safe storage and monitoring of vaccines or to ensure medicines and equipment required for resuscitation and other medical emergencies were maintained in date.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The practice did not have a copy of its complaints procedure on display. The practice complaints policy was out of date. The practice did not provide patients who had made a complaint with information about how to take their complaint further should they be dissatisfied with the practice response. The practice was unable to demonstrate there was a system in place for analysing and learning from complaints, or any training needs identified.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The practice did not undertake adequate checks to ensure information from Schedule 3 of the Health and Social Care Act (Regulated Activities) Regulations 2010 was available for all staff. Risk assessments were not in place for roles that were considered by the practice to not require a criminal record check.