Corner Place Surgery

Quality Report

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Date of inspection visit: 3 June 2015
Date of publication: 03/09/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Corner Place Surgery on Wednesday 3 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all of the population groups, with the exception of older people, which we found to be an outstanding service..

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- There were effective staff recruitment, induction and training processes in place. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Feedback from patients was consistently good. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and health promotion was managed well.
- Patients knew how to complain and information was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP and said that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs, although the minor surgery room needed to be decluttered to reduce the spread of infection.
- There was a sense of team work amongst staff with opportunities for peer support and interaction. Communication was good and there was a clear

Summary of findings

leadership structure. Staff felt supported by management and the GPs. The practice proactively sought feedback from staff and patients, which it acted on.

We considered that the care of older people was outstanding. This can be demonstrated by:

The practice had been instrumental in setting up a care homes forum which had been welcomed by care home registered managers in the locality. The forum provided training for staff in matters such as end of life care and the management of challenging patients.

The GPs and staff had an effective multi disciplinary/ voluntary sector approach which included introducing services which had an impact for patients. For example, providing transport services, introducing services to reduce isolation and working with other service providers.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement but evidence showed that follow up of these events was not performed systematically.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Medicines were well managed.

There were enough skilled staff recruited to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback and data showed that patients rated the practice higher than others for several aspects of care.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and responded to their needs. For example, the practice had a higher than average number of older patients and had introduced services to meet their needs. The practice also engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.

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 that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

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

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The Practice had a higher than average number of older patients and had been responsive in their care.

The practice operated a personal list system for all patients, although patients still had a choice of seeing their preferred GP.

Older people were offered appropriate vaccinations such as flu, pneumonia and shingles according to national guidelines. The practice worked with community nursing teams to ensure that people who are unable to visit the practice receive their vaccinations. A practice nurse visited those patients not on the community nurse list.

Doctors visited patients who were unable to come to the practice. The practice had a rota system to ensure there was a GP who was available for urgent visits which meant that patients requiring secondary care assessment arrived at hospital earlier in the day..

The practice was in the process of employing a pharmacist whose job description would include reviewing hospital discharges and rationalise medications which planned to make the hospital discharge process more efficient.

The practice held fortnightly multi-disciplinary meetings which were attended by community teams including the community matron. Additional meetings were organised to review patients on the practice proactive care management list. The practice work with other agencies to develop better multi-agency teams, such as the recent 'BIG Team' project. The Big Team was a local pilot scheme and consisted of two GPs and a nurse based at Paignton Hospital with the intermediate care team. The pilot ran for four months and practices could refer their particularly complex patients, who were then given intensive input by the Big Team. The objective was to reduce unplanned admissions, the impact of the pilot is currently being reviewed. Anecdotally, the GPs had found it eased pressure on home visits and patients found it very supportive. The practice were waiting to see if the scheme was going to continue.

The practice had taken part in a care homes pilot within the locality, carrying out annual reviews of residents with a community pharmacist. The review included drawing up and agreeing a care plan with the patient regarding their care and treatment wishes.

Summary of findings

The practice had been instrumental in setting up a care homes forum which had been welcomed by care home registered managers in the locality. The forum provided training for staff in matters such as end of life and the management of challenging patients.

The practice had an active patient support group called 'Corner Care' which provided patients with social activities and some transport to appointments.

A carer support worker was present at the practice one day each week. This member of staff maintained a register of carers and carried out home visits to assess need, support, and to signpost patients and carers to appropriate services.

The practice engaged with the local voluntary sector and was starting to work with projects such as 'Ageing Well' which set up guided conversations and promoted social prescribing within the practice. Social Prescribing is a process of linking people up to activities in the community that they might benefit from which helps people experiencing from a range of common mental health problems.

People with long term conditions

Good

The practice used a computer system to identify patients with long-term conditions and offered clinics in diabetes, asthma, chronic obstructive pulmonary disease (COPD), leg ulcer dressing and hypertension. The practice had ensured that more than one nurse was trained to diploma level for all long term conditions and enabled staff to attended regular updates to ensure their knowledge was up to date.

Two of the practice nursing staff were trained to provide insulin initiation. One practice nurse visited housebound patients with diabetes to review their care and treatment. Practice staff liaised with community staff such as the specialist COPD nurses and district nurses to manage conditions of patients who are unable to attend surgery. The nursing team also worked closely with secondary care specialists, particularly in diabetes and leg ulcer management.

Retinal screening was carried out on the premises by visiting hospital technicians one afternoon per week. In addition to the practice nurses, there was a Healthcare Assistant (HCA) who was trained and skilled in spirometry testing. The HCA also offered weight management clinics, smoking cessation and NHS Health checks.

Summary of findings

The practice encouraged self-care and engaged with the locally provided self-care scheme. The scheme was commissioned by the CCG. Cornerplace surgery patients were then referred for bespoke self-care support which was given by way of a self-care coach and on-line tools.

The practice had a system in place for notifying the out-of-hours service provider of any patients who are particularly vulnerable. This meant patients could receive emergency care form staff who were aware of the patient's conditions and current well-being.

Families, children and young people

Good

A children's play area was provided in the main waiting room and there was space for pushchairs to be brought into the surgery. Private areas were available for mothers to breast feed in privacy.

Midwives visited the practice and were provided with a clinic room three half-days each week to provide antenatal care.

Patients were provided with the full range of contraception services, including implants and coils. Doctors providing these services were accredited with the Faculty of Sexual and Reproductive Healthcare. Cytology screening was provided at the practice and Monday evening appointments with a nurse were available for contraceptive advice.

There was a young people's notice board, with leaflets provided in a less public and more private area. Sexual health screening kits were available in discreet areas. There was information on the website particularly for young people, including their right to confidentiality. Staff had access to training updates on dealing with young people.

One of the GPs provided a weekly session for 'Tic Tac', a young people's drop-in clinic at Paignton Community College. The TICTAC service is a teenage advice service, offering a safe, young people friendly space for all young people to come to for help, advice, information or support about anything at all that is concerning them.

A supply of free condoms is kept at front desk at the practice as part of the C-Card scheme, where young people are able to access condoms in a discreet and confidential manner. Young people can see the practice participate in the scheme through displaying the logo on its entrance door.

Summary of findings

Working age people (including those recently retired and students)

Good

The Practice offered same day and advance appointments. Evening appointments were offered on Mondays and from 7.30 am on Tuesdays. The practice offered on-line booking of GP appointments and text reminders. Prescriptions could be ordered on line, by phone or by post.

The Practice mantra was to do "today's work today". Patients who could not be given a routine appointment were invited to come down at 5.00 pm to the sit and wait surgery if they felt they must be seen that day. Alternatively, patients were offered a telephone consultation appointment.

Three nurses at the practice were skilled and experienced to offer travel advice and used a professionals online website for up to date information on vaccinations.

There were several language schools in the area and the Practice has a good reputation for being accommodating to temporary residents from overseas.

Invitations were sent monthly for patients aged between 40 and 74 to receive the NHS Healthcheck. These were provided by the HCA.

Opportunistic health screening was available and promoted by staff at the practice.

The Practice had a high rate of electronic prescribing providing convenience to patients who could use their pharmacy of choice and collect their medication at their convenience.

People whose circumstances may make them vulnerable

Good

There was a vulnerable patient register which was reviewed at fortnightly MDT meetings. When these patients phoned for an appointment they were identified by reception staff as needing urgent contact with a doctor and either fitted in with a same-day appointment or telephone access.

Patients with learning disabilities were invited for an annual health-check using the easy-read invitations recommended by the learning disability service.

Patients with alcohol addiction and/or substance misuse were referred to local services and the practice provided a room for them to be seen on site by the external agency if required.

There were very few patients from ethnic minorities, in line with local demographics. When translation services were required the practice used a multilingual translation service, details of which were available on the Practice intranet.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice had a lead GP for mental health issues who was also the Clinical Commissioning Group (CCG) lead for mental health and plays a significant role in the re-design of services.

A counsellor from the Devon Partnership Trust Depression and Anxiety service worked from the practice one day per week. Over the past few months, a community pharmacist had also been carrying out face-to-face medication reviews for patients with mental health problems.

Dementia diagnosis rates at the practice were amongst the highest in Torbay. The practice had recognised the importance of improving care for dementia patients and was involved in implementing care planning for this group of patients. Recent care home reviews by the GPs had led to several new diagnoses of dementia. The Practice were taking part in a pilot working with another doctor on the use of Skype in care homes for the management of patients with delirium.

Staff were aware of the Mental Capacity Act and had access to guidance on the Practice intranet.

Summary of findings

What people who use the service say

We spoke with 20 patients during our inspection and with two members of the patient participation group.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 17 comment cards, 14 of which contained positive comments. There were three negative comments relating to getting through on the telephone.

Comment cards were detailed and stated that patients appreciated the professional attitude, the helpful staff, and the caring and respectful service provided. Patients fed back about the building being clean and tidy and praised the GPs, reception staff and nurses.

These findings were reflected during our conversations with the 20 patients we spoke with and from looking at the practice's 290 friends and family test results from January 2015 to April 2015 and from the practice patient survey from January 2014. The feedback from patients was consistently good. Patients told us about their experiences of care and praised the level of individual care and support they received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent. Of the 290 friends and family test results we saw 269 patients said they were extremely likely or likely to recommend the practice. There were 14 other results which stated patients were neither likely nor unlikely. Seven of the 290 respondents said they would be extremely unlikely to recommend the practice. The reasons were given in the format of comments and related to telephone response times. There were many positive comments to support the other findings.

Patients were happy with the appointment system but said that getting through on the telephone was a problem. This had been identified in other surveys. The practice told us there were ten phone lines and that extra staff worked at peak times of the day to manage calls. Patients said that being able to speak with a GP on the telephone worked well. Parents said they could always make a same day appointment for their children. We were told that no patient would be turned away.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients said they found it easy to get repeat prescriptions processed.

Outstanding practice

The practice were outstanding in the care of older people. This can be demonstrated by the following examples:

The practice had been instrumental in setting up a care homes forum which had been welcomed by care home registered managers in the locality. The forum provided training for staff in matters such as end of life care and the management of challenging patients.

The GPs and staff had an effective multi disciplinary/ voluntary sector approach which included introducing services which had an impact for patients. For example, providing transport services, introducing services to reduce isolation and working with other service providers.

Corner Place Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Corner Place Surgery

Corner Place Surgery was inspected on Wednesday 3 June 2015. This was a comprehensive inspection.

Corner Place Surgery in the seaside town of Paignton, Devon. The practice provides a primary medical service to approximately 12,600 patients of a diverse age group. Almost 16% of the patients are above the ages of 65 which is similar to other practices in the locality.

There are a team of seven GP partners and two salaried GPs within the organisation. Partners hold managerial and financial responsibility for running the business. There are four male and five female GPs. The team are supported by a practice manager, five practice nurses, one health care assistant, a phlebotomist and 16 administration, reception and office staff.

Patients using the practice also have access to community staff including community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The phone lines for the practice are open from Monday to Friday, between the hours of 8.00am and 6.00pm. Patients can visit reception from 8.15am until 6pm. Appointments are available between these times. Monday evening routine appointments until 8.15pm are available for people who were unable to access appointments during normal opening times.

The practice has opted out of providing out-of-hours services to their own patients and referred them to another out of hour's service.

Why we carried out this inspection

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

How we carried out this inspection

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?

Detailed findings

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

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

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

We carried out our announced visit on Wednesday 3 June 2015. We spoke with 20 patients, two members of the patient participation group, six GPs, four of the nursing team and members of the management, reception and administration team. We collected 17 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, the practice used reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff said there were plenty of opportunities to discuss incidents including informally at daily coffee meetings and more formally at the fortnightly partnership meetings, monthly staff meetings and monthly significant event meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of five significant events that had occurred during the last three years and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to discuss events and decide on any action or learning if it had not taken place already. However, we noted that this meeting did not formally record the review of actions from past significant events and complaints. There was evidence from discussion with GPs and nurses that the practice had learned from these events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff told us that when they were involved in a complaint or incident they filled out an online form which was then sent to the practice manager. Staff explained it was discussed with them but they were also supported through the process and there was a no blame culture which used any event as a way to improve safety and care. We saw evidence of actions taken as a result and that learning had been shared. For example, nursing staff had given the wrong brand of vaccine to a child. The nurse raised this immediately and consulted with public health England who explained no harm would be caused. The family were contacted, given an apology and the child was called for an additional vaccine. Additional learning had taken place and the incident was discussed and reviewed at staff appraisal.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The practice were working towards ensuring all GPs were trained to level three and nursing staff to level two as a minimum. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had an appointed dedicated GP as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware of who these leads were and who to speak with in the practice if they had a safeguarding concern. Policies and guidance were located on the staff intranet system which could be accessed from any computer at the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or very vulnerable patients. There

was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. The practice held fortnightly meetings with health visitors and social workers where safeguarding issues could be discussed.

There was a chaperone policy for staff to access. There was a small chaperone poster on the waiting room noticeboard which the practice manager was in the process of enlarging and including in all consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone and had received a recent update in this role. Reception staff would act as a chaperone if nursing staff were not available. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out daily which ensured medication was stored at the appropriate temperature. Records were seen to show this process was monitored.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic and anti-psychotic prescribing within the practice. There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been signed by all staff. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. These documents were generated and stored on each patient record. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. For example, a nurse had given a different branded vaccination. Nursing staff were all reminded of the correct policy and this was discussed at the daily informal coffee meetings and at the significant event monthly meetings.

The practice used electronic prescribing and had established a service for patients to pick up their dispensed prescriptions at a location of their choice and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be clean and tidy. However, the room used for minor surgery contained additional equipment and material which would prevent the room being cleaned effectively. We saw there were clinical

cleaning schedules in place and electronic cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. For example, the last audit had taken place in April 2015 and had highlighted a need to remind all staff, including GPs, about the clinical cleaning schedule. Minutes of practice and nurses meetings showed that the findings of the audits were discussed.

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

The practice performed an annual risk assessment for the management of legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested every two years and was due to be retested later this year. Equipment displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. This was either done by an external contractor or the local medical electronics department at Torbay hospital.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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). We looked at a new member of staff file to see ifthese checks had taken place prior to a start date in September 2015.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the GPs and all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The GP rota was complex but ensured home visits and review of blood tests would take place in the short and long term absence of the GPs.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service

and staffing changes (both planned and unplanned) needed to be included on the log. We saw an example of this and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a central, secure area of the practice and all staff knew of their location. Medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in the last year. Staff knew that this document was stored on the intranet.

The practice had carried out a fire risk assessment in January 2015 that included minor actions required to maintain fire safety. For example, the need to supply additional signage for electrical risks. This was actioned immediately. Records showed that staff were up to date with fire training and that they practised regular fire drills. The last one was performed with 16 members of staff in January 2015. There was a rolling programme to service the fire alarms, fire extinguishers and emergency lighting.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff during the informal coffee meetings and through the more formal practice and team meetings. We saw minutes of some of these meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. Staff also said they used online tools such as travel vaccine advice to make sure patients received up to date care.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required. We saw that patients were involved in this process and in the area of learning disabilities were given easy read assessments before their appointment so they had time to discuss with carers and ask questions.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Staff explained that this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened. Staff said there was no hierarchy with this process and gave examples where the GPs would ask advice from the nursing staff about wound management and long term conditions.

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

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by named members of staff and used to support the practice to carry out clinical audits.

The practice sent us 13 clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit invited 18 poorly controlled diabetic patients to have a review of their medication and insulin. Thirteen of these patients took up the offer of a review. This had resulted in blood sugar being better controlled in all 13 patients. Other examples included audits to confirm that the referral rate for suspected cancers was managed in a timely way and were appropriate. One GP had performed an audit over the course of a year during which they had

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Are services effective?

(for example, treatment is effective)

made 17 two week referrals. Four of these were confirmed cancers and all had been referred within the timescales. For all the audits we saw the GPs and nurses were able to describe the findings but we noted there was a lack of systematic approach to documenting the lessons learnt or having a prompt to revisit the audit to ensure the changes were maintained or improved upon.

GPs who undertook minor surgical procedures also performed audits to show they were doing so in line with their registration and National Institute for Health and Care Excellence guidance. For example, the minor surgery audit showed 149 patients had received minor surgery or had contraceptive devices fitted. The audit listed the batch numbers of any equipment used. None showed any complications or infections. However, histology results were only listed for 13 of the 96 minor surgery interventions for the removal of skin tags, warts, lumps and bumps. Staff explained that any results were seen by the GP and filled in the patient's electronic record. We saw this had occurred but noted that there was no system in place to monitor that histology results had been reviewed when they had been returned. We saw no records of carcinomas being found.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, the GPs were using a scoring system when assessing patients with a particular heart condition to predict of them developing a stroke and to determine whether or not to start anticoagulant therapy. Meeting minutes showed communication of these findings were discussed and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, Performance for mental health reviews was 95.7% which was better than the national average of 86.09%. The performance of diabetes related indicators was 92.5% also better than the national average of 78.5%. The GPs told us these figures had improved since last year through additional clinics and better data input.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. For example, last year's figures had identified lower than expected figures which had led to staff being reminded to enter codes for tests correctly.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement and an eagerness to 'get things right'.

The practice's prescribing rates were similar to national figures. For example, the use of broad spectrum antibiotic use was 4.07% which compared to the 5.57% national average and within guidelines suggested by NICE.

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

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

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

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(for example, treatment is effective)

undertaken for people with long term conditions. For example, 684 patients out of the 829 patients (82.5%) with diabetes had received a review and 263 out of 323 patients 81.4% with COPD had received a review.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. For example, some of the GPs had special interests in minor surgery, dermatology, cardiology, mental health, palliative care, and teenage health. The nursing staff also had special interests in areas such as long term conditions, child health, travel health and wound care.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The nursing staff were all on the Nursing and Midwifery professional register.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example nurses had attended training relevant updates needed for their roles. For example, travel vaccinations, cervical screening and infection control. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. One of the GPs was a lead for the education at the practice and one of the salaried GPs had been a trainee at the practice.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example diabetes management and seeing patients with other long-term conditions were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a clearly defined rota system outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a named GP on the day they were received. Discharge summaries and letters from outpatients were seen and actioned on the day of receipt. One GP stated that there was a 'todays work today' ethos at the practice which was adopted by all staff. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

There were many examples shared of effective working with other services at the practice. For example, one of the GPs provided a weekly session for 'Tic Tac', a young people's drop-in clinic at Paignton Community College. The practice also worked with counsellors from the Devon Partnership Trust Depression and Anxiety service who worked from the practice one day per week.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. The practice were in the process of employing a community pharmacist to assist with medicine reviews following discharge from hospital. The GPs had also been part of a pilot called the Big Team scheme which consisted of two GPs and a nurse based at Paignton Hospital with the intermediate care team. The pilot ran for four months and practices could refer their particularly complex patients, who were then

given intensive input by the Big Team health care professionals. The objective was to reduce unplanned admissions and the impact of the pilot was currently being reviewed.

The practice held multidisciplinary team meetings fortnightly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, health visitors, palliative care nurses and decisions about care planning. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with completing the treatment escalation plans used in the area. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Care plans were provided in an easy read format to give patients with a learning disability the information they needed. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures written consent was obtained. Where a patient's verbal consent was sought this was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures such as ear syringing and immunisations and all staff were clear about when to obtain written consent.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that on average 10 patients a week in this age group take up the offer of the health check. We were shown the process for following up patients within a week if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering

Good

Are services effective?

(for example, treatment is effective)

additional help. For example, the practice had identified 3623 patients were registered as smokers. The practice had actively offered nurse-led smoking cessation advice to 36% of these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 33 (2.6%), which was average compared to neighbouring practices and national figures. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 80%, which was above the national average of 40-80%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 70% to 90% and five year olds from 70% to 90%. These were comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from January 2014, a survey of 489 patients undertaken by the practice regarding telephone access and 290 patient satisfaction questionnaires sent out as part of the friends and family test from January 2015 to April 2015

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. 86% of the 291 respondents said they were treated with respect. This was higher than the national average of 84%.

The practice was also well above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 84% of the 291 respondents said the GP was good at listening to them compared to the national average of 82%.
- 81% of respondents said the GP gave them enough time compared to the national average of 78%.
- In addition 84% said they had confidence and trust in the last GP they saw compared to the national average of 82%.

These findings were reflected in the friends and family test results. We saw many comments regarding being treated with respect and consideration.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and all were positive about the care and treatment patients experienced. We also spoke with 20 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We received three negative comments which all related to getting through on the telephone. There were no negative comments about the care provided.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a wall which helped keep patient information private. The patient survey found that 75% of patients thought there was respect for privacy and confidentiality. This compared well to the national average of 72%.

The national patient survey also found that 76% of patients found the receptionists at the practice helpful compared to the national average of 72%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 83% said the last GP they saw was good at explaining tests and treatments compared to the national average of 80%.

84% said the last GP they saw was good at the ability to listen and 83% said the GP was good at giving explanations. These scores compared well to the national averages of 82% and 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. The nursing and reception staff said that longer appointments were available should patients have more than one condition to discuss.

Good

Are services caring?

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 81% said the last GP they spoke to was good at treating them with concern compared to the national average of 80%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice worked with a community carer support worker who attended the practice once a week and offered information on matters such as benefits, respite care, support groups and practical help.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was followed by a patient consultation by a GP familiar with the patient's family. The practice also sent a card of sympathy to the remaining family member.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had a higher than national average of older people who were at risk of admission to hospital. As a result the practice had become involved in schemes and pilots to reduce unnecessary admissions. These included the GPs working in care homes to ensure patients had up to date care and treatment escalation plans which reflected their wishes about treatment at the end of life. The practice had taken part in a care homes pilot within the locality, carrying out annual reviews of residents with a community pharmacist.

The GPs had also worked with intermediate teams to prevent unnecessary hospital admission and had arranged frequent (fortnightly) multidisciplinary team meetings to discuss vulnerable patients. The GPs and staff also worked with voluntary workers and outside agencies to ensure older people and carers had the support and information they needed. This was done by inviting a carer support worker to the practice once a week and working with the voluntary sector to look at initiatives such as social prescribing which aimed to facilitate self help and reduce loneliness and isolation.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example, patient surveys and feedback on the friends and family survey had highlighted dissatisfaction with getting through to the practice on the telephone. This had resulted in the practice conducting follow up a specific survey in June 2014 on telephone access. The initial survey resulted in administration staff helping with early morning calls. A further survey was repeated in November 2014 which showed a significant improvement. Patients then suggested reducing the length of the answer phone message which was done in May 2015.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and those with multiple long term conditions.

The majority of patients were English speaking which reflected local demography. However, access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties. Consulting rooms were on both floors but patients with mobility problems would be seen on the ground floor. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were male and female GPs in the practice, therefore patients could choose to see a male or female doctor.

Access to the service

The phone lines for the practice were open from Monday to Friday, between the hours of 8.00am and 6.00pm. Patients could visit reception from 8.15am until 6pm and appointments were available between these times. Monday evening routine appointments until 8.15pm were available for people who were unable to access appointments during normal opening times.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

with learning disabilities and those with multiple long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes by the GPs.

We received three negative comments which all related to getting through on the telephone. The practice staff explained this had been highlighted in an earlier survey and within the friends and family test results. As a result the practice had conducted two further specific surveys on telephone satisfaction. The first, performed in June 2014 resulted in additional administration staff assisting with the incoming calls each morning. The follow up survey in November 2014 showed a marked improvement in satisfaction and an introduction of a shorter message and publication of the telephone system.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. The patients we spoke with confirmed that improvements had been made but showed patients still experienced problems at busy times of the day.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This included information on the website, leaflets and posters at the practice and by speaking with reception staff. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 11 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way, with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, a delay in an X-ray referral had resulted in GPs now making referrals by email rather than fax to keep an audit trail to show the referral had been made. The patient had received an apology.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice was organised, well led and had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose and discussed during partners meetings. We saw evidence the strategy and business plan were regularly reviewed by the practice. The practice aims and objectives were listed in the statement of purpose which is displayed on the practice website. The practice priority was to provide the highest standard of clinical care, ensuring they worked collaboratively with other healthcare providers and support organisations, to enable more patients to be treated in a primary care setting, closer to home. The statement of purpose also included clear aims and objectives of the practice.

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke about being part of a team and playing a part in delivering high quality patient care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a selection of these policies and procedures and found they had been reviewed annually and were up to date. Staff said they were alerted to any update by email or at the regular staff meetings.

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

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice had performed a study of non-two week wait breast cancer referrals following information that the practice referral rate was higher than average. The study found that only one of 17 patients had indicated a required change of practice to be considered. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, fire safety, work station safety and legionella. The practice had monitored risks on a minimum of an annual basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We saw a number of policies, which were in place to support staff. For example, recruitment and disciplinary process. The practice had a whistleblowing policy which was also available to all staff in on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were

Are services well-led?

Good

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

involved in discussions about how to run the practice and how to develop the practice. The partners met daily for a coffee and used the time for peer support, informal discussion and for division and allocation of work. The partners encouraged all members of staff to meet wherever possible and to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and supported if they did. Staff explained if there were any suggestions or ideas these did not have to wait for a formal meeting and that they could speak with the practice manager at any time. Staff said they felt respected, valued and supported by the partners, practice manager and other GPs in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the old virtual patient participation group (PPG) and the newer face to face group. We spoke with two members of the PPG and they were very positive about the role they hoped to play and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice manager also used surveys, feedback from NHS choices and complaints received to improve services. We saw the analysis of the last patient survey. The results and actions agreed from these surveys were available on the practice website and displayed on a poster in the waiting room. We saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing and had conducted further surveys to gain specific feedback about appointments and access to the practice.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal learning plan. Staff told us that the practice was very supportive of training and that they had training events where guest speakers and trainers attended.

The practice was a GP training practice and had been successful in recruiting salaried GPs who had gone through the practice as trainees.