Pembroke House Surgery

Quality Report

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Date of inspection visit: Monday 7 July 2014
Date of publication: 24/10/2014

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.

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Overall summary

Pembroke House Surgery is situated in Preston, Paignton. The practice was purpose built and had the facilities to meet the needs of its patients with disabilities. The practice served approximately 10,000 patients. The main services provided include; long term condition care, minor surgery, contraceptive care, baby clinics, well person checks and travel immunisations.

During our inspection we heard from 35 patients including 26 views gained from completed comment cards left by us in the practice. The nine patients spoken with on the day included three members from the patient panel, who assist the practice with views of the service so improvements to the service could be made. All the views expressed by patients about the practice were very positive with a collective view that patients were at the centre of the practice service delivery.

We found the provider had taken steps to ensure the practice was safe for patients as well as to the staff employed there. There were systems in place to ensure effective patient care and we heard about a high level of patient satisfaction with the care and treatment provided. Patients were treated with dignity and respect in a purpose built environment which was accessible and ensured their privacy. The appointment system enabled patients to be seen quickly for the amount of time their needs required. The practice was responsive to the needs of the patient and continuously strived to improve the service it provided through active engagement with the patient group. The practice was well led by the practice manager and their partner GPs. They were supported by an engaged practice nursing and staff team.

Patients over the age of 75 had been allocated a dedicated GP to oversee their individual care and treatment requirements delivered in the practice or in the patients own home.

Mothers, babies, children and young people had access to dedicated specialised staff as well as dedicated practice clinics, such as child immunisations.

The practice made provision for the working-age population and those recently retired with running Saturday clinics as well as telephone consultations.

Patients in vulnerable circumstances who may have poor access to primary care were provided with services by the practice.

Patients experiencing poor mental health were supported by the practice and had close links to the local mental health crisis team to ensure prompt referrals, when necessary.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found the practice had safe arrangements in place to report and record incidents and staff understood their role and accountability in reporting incidents.

The practice learnt when things went wrong and actively sought to improve the service to ensure patients received good quality care.

The practice had comprehensive policies and procedures in place to keep patients safe and staff were aware of their responsibilities in management of things such as, infection control, safeguarding vulnerable patients, management of medicines and safe use of equipment.

Staffing levels and skills mix were assessed regularly to ensure access to appointments and patient safety. There were plans in place to deal with medical emergencies.

There were systems in place to ensure the practice could efficiently deal with any foreseeable emergency.

Are services effective?

Patients received an evidence-based assessment which ensured care and treatment was delivered in line with the latest national standards.

The practice regularly monitored positive outcomes for patients and compared it to others including undertaking clinical audits and holding regular meeting with other professionals.

The practice had staffing, equipment and facilities which enabled an effective delivery of care.

The practice supported and enabled regular multidisciplinary working with other services that ensured the best possible care was provided to its patients.

The practice supported patients who required health promotion and preventative care.

Are services caring?

Staff treat patients with kindness, dignity, respect, compassion and empathy.

Patients understood their treatment and were involved in decision making about their care and treatment.

Summary of findings

Patients could involve their partners or carers when they chose. Staff demonstrated a good understanding of consent and decisions made in the patients best interest.

Patients were provided with emotional support when they needed it and signposted to support networks.

Are services responsive to people's needs?

The practice planned and delivered services to meet the needs of different patients.

The practice had a good appointment system that enabled them to provide care and treatment at the right time.

Patients needs and wishes were understood by staff and influenced care and treatment through referrals to secondary health care.

Patients concerns and complaints were listened to and acted upon to improve the service overall.

Are services well-led?

The practice had a clear vision and strategy to deliver high quality care.

The practice governance arrangements provided clear decision making and engagement with others.

The leadership and culture of the practice reflected a supported and motivated staff team and an open and transparent team working environment.

The practice sought the views of patients and acted on feedback from patients and staff.

Staff objectives focussed on improvement, learning and performance was regularly reviewed and improved.

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 had a higher than national England average older patient population. The practice operated a system where patients who were 75 years old and above were allocated a named GP. These patients were given priority to see their allocated GP when they requested an appointment. The GPs conducted home visits and visited patients at local residential and nursing homes.

There were weekly meetings with a multi-disciplinary team consisting of community district nurses, social workers and the palliative care team to discuss and meet the needs of patients with complex health care needs.

People with long-term conditions
Patients with long term conditions were well supported to manage their health, care and treatment. They benefitted from effective information and guidance from the practice about the management of their conditions. The practice offered a range of clinics during the week run by specially trained nurses for patients with long term health conditions.

Mothers, babies, children and young people
The practice had a variety of clinics to assist mothers, babies and young children. Staff worked closely with onsite health visitors and locally based community midwives to identify children who were at risk and ensure they received appropriate care and treatment. Parents we spoke with told us the staff had good communication skills and were good at explaining care and treatment options to younger patients.

The working-age population and those recently retired
The practice provided a variety of ways working aged patients (and those recently retired), so they could access primary medical services. These included the ability to book appointments online, telephone consultations with GPs and Saturday clinics.

People in vulnerable circumstances who may have poor access to primary care
Staff had developed links with patients in vulnerable circumstances. The practice had a system to ensure patients with a learning disability were identified and received an annual health check.

Summary of findings

People experiencing poor mental health

The practice had supported patients experiencing mental health problems. The assessed patients care and monitored their physical health by encouraging patients to visit for an annual health check. The practice allocated specific GPs for patients diagnosed with mental health conditions to improve their continuity of care.

Summary of findings

What people who use the service say

During our inspection we spoke with nine patients who told us they were very satisfied with the service received. Patients described the practice as brilliant, can't fault the place and very pleased with the service received.

Twenty-six patients completed our comment cards and we found these showed a high level of satisfaction with all areas of the service provided including comments made about staff being respectful and considerate, GPs listening to patients and providing clear explanations of the problem. The practice had recently implemented a new appointment system and patients fed back the benefits of this, such as being seen the on the same day. This was particularly beneficial for a patient with a long term condition.

The practice had a patient panel that consisted of approximately 28 members. The practice arranged quarterly meetings with these members to discuss any improvements that could be made to the practice. The practice involved the panel in decisions that would affect patients, such as changing the appointment system and implementing a new electronic prescriptions system. This enabled patients to pick up their prescriptions at a pharmacy of their choice without attending the practice to pick up the prescription. Patients who attended the panel said their voice was heard by the practice and taken into account when decisions were made to improve the practice.

The practice completed an annual patient satisfaction survey. The last one had been completed for the year 2013-2014. This showed an 87% satisfaction rate for all aspects of the service from the 271 patients surveyed. The survey showed the least satisfactory area of the services provided was the telephone access system. The survey had been completed before the practice had implemented the new appointment system and electronic prescriptions. They were anticipating this satisfaction to be increased in the next survey.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure recruitment procedures were improved to ensure all staff had appropriate checks taken prior to being employed by the practice.

The practice should have good medicine management systems in place to account for medicines that had been ordered and/or administered.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

One of the GPs from the practice formed a charity which started in 1978. This group provided a voluntary service for transport, social activities, support and information to the elderly, frail and sick patients of Pembroke House Surgery and the local area. Pembroke House Surgery maintained a current active involvement in supporting this service.

GPs carried out bereavement checks with patients relatives three months after the patients death to check how the relative was coping and if they needed any additional support.

Pembroke House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Inspector and supported by another CQC inspector. In addition, the team included a specialist GP advisor with a range of experience in the general practice sector including; over forty years clinical experience thirty eight years as a GP, which included several roles in NHS management providing the NHS with GP perspective of practices and informing GPs with information on the NHS directives. They are also currently a general practitioner appraiser.

Background to Pembroke House Surgery

Pembroke House Surgery is based on 266 Torquay Road, in the Preston area of Paignton. It supports approximately 10,000 patients predominately in the TQ3 post code area and some of TQ2 and TQ4.

The practice website informed us they predominantly have white British patients with 0.1% of patients from minority ethnic groups. The practice is in an area of low deprivation and there are a high number of patients aged over 60 years equating to 36% of the practice patient base and out of this 36% of patients 15% were over 75 years old. The practice does not support any specific residential care or nursing homes instead patients were registered with practices in the area of their choice. The practice manager told us they were involved in approximately 20 care and nursing homes in the area. The patient panel is made up of 28 representatives from the majority of patient groups.

The practice used an interpretation service on a number of occasions to support patients whose first language was not English. Previously Polish, Romanian and Chinese interpretation services had been used.

The practice is open six days a week and provides patient appointments between 8am and 6pm Monday to Friday and 8am till 12:45pm on Saturdays. Six GPs cover appointments on Mondays and five GPs provide appointments from Tuesday to Friday with Saturdays having on GP present. Practice nurses were similarly flexibly available and there was always at least one practice nurse working from 8am to 6pm.

The practice employs eight GPs, five partners, two salaried GPs and a trainee GP. A team of four practice nurses and three health care assistants and 14 administration/ reception staff were also employed by the practice. During our inspection we spoke with 15 members of the practice team including six GPs, six practice nurses and three health care assistants.

The practice is a GP training practice, and as such normally had a GP registrar working in the practice. A GP registrar is a trainee GP in their final years of training, gaining GP experience before entering General Practice as a fully qualified GP. The current registrar GP had started working in the practice in February 2014 and was due to complete their training period by August 2014.

The practice opted out of providing Out of Hours service to its patients. This was provided by an alternative provider.

Detailed findings

Why we carried out this inspection

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

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- 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 visiting, we reviewed a range of information we had received from the practice and asked other organisations to share their information about the practice. Other organisations included the local Healthwatch, NHS England and the local clinical commissioning group. We asked the provider to send us information about their service before the inspection took place to enable us to prioritise our areas for inspection. We reviewed the practice website and looked at information provided by the NHS Choices website about the service.

The three person inspection team carried out an announced visit on 7 July 2014. During our visit we spoke with eight patients and a range of staff; five GPs, three practice nurses, two health care assistants, the practice manager, receptionists and administration staff. We observed how people were cared for and talked with family members. We reviewed comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

There were effective arrangements in place to report safety incidents in line with national and statutory guidance. The GPs, practice nurses and lead staff for administration and reception had regular monthly clinical governance meetings that raised any significant incidents. These incidents were discussed and minutes showed actions to address the incident had been taken. They also included any involvement with outside agencies. For example, on one occasion there had been a prescription error and the wrong medicine was prescribed for the patient. The practice decided they would discuss learning with the pharmacy involved. As a team incidents were discussed and action taken where needed to provide overall improvements to the practice.

Staff we spoke with were aware of how and who to report incidents to within the practice. All staff we spoke with told us they felt very able to raise any concern however small with the team as a whole. The practice manager told us they had an open door policy and gave examples of when staff had raised concerns with them individually. We saw meeting minutes where how to safeguard vulnerable adults was discussed and what staff responsibility was for reporting any safeguarding incidents.

Learning and improvement from safety incidents

The practice showed they had a system in place to continuously learn from when things go wrong. Staff meeting minutes showed evidence of learning from incidents and discussions held with teams on improvements to the service. The practice manager told us of an incident when a care home had called the practice for an urgent call back. The care home did not receive a call back for a number of hours at which point an ambulance had been called and the patient admitted to hospital. The practice had taken action following this and this incident formed part of their decision to implement and transform the patient appointment system.

Reliable safety systems and processes including safeguarding

One of the GP partners had a practice lead responsibility for ensuring safeguarding of children. All GPs had been trained annually on level 3 child protection training. There was a practice expectation that all nursing staff were level 2 trained and administration staff were trained in level 1. Another GP had lead responsibility for safeguarding vulnerable adults. In-house training had been provided to all staff for safeguarding vulnerable adults. We were told by the practice manager that all three GPs completed annual safeguarding training. We saw evidence that staff of all levels had completed training in safeguarding children and vulnerable adults.

There were a number of children known to the practice on the child protection register and the practice held a vulnerable family register. This included families where an individual may have a social, drug, alcohol or learning problem as well as children at risk. The GP lead for child protection held a monthly meeting with the multidisciplinary team which included a midwife and health visitor. This was an opportunity to discuss children at risk and have a coordinated approach with other professionals that enabled protection plans to be implemented effectively. The practice regularly discussed adults at risk each week with a multidisciplinary team.

All the staff we spoke with demonstrated a good understanding of the types of abuse which might occur as well as the signs and symptoms of abuse. Staff understood their responsibilities and what action they should take if abuse was suspected. The practice had policies for child protection and at risk adults, these included detailed information on how to recognise abuse and what action to take.

The patients we spoke with told us they felt safe in the practice and that their care and support was delivered by competent and professional staff. The practice had a chaperoning policy available to all patients which ensured all vulnerable patients had the opportunity to see a GP or nurse accompanied by a skilled and knowledgeable chaperone.

Monitoring safety and responding to risk

We saw that staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. For example, six out of the seven GPs were available on Monday, the busiest day for the practice. The practice had five GPs working from Tuesday to Friday which met patient demand. Practice nurses were similarly flexibly available and there was always at least one practice nurse working from 8am to 6pm. Patient registrations had increased from 7000 to 10000 since the practice moved premises in 2011. The practice had employed an additional GP to cover

demand. When the practice implemented the new patient appointment system, they analysed their capacity and employed an additional health care assistant to meet patient needs.

The practice manager had a system for monitoring annual leave to ensure staffing levels were kept stable. For example, the GPs were separated into two groups; male and female and only one member from each group could take time off at the same time. This enabled the practice to ensure there was always a mix of male and female staff so patients had a choice of who they could see. This showed the right staffing levels and skill-mix was sustained during the hours the practice was available. This helped ensure safe, effective and compassionate care and supported staff well-being.

Staff knew how to recognise and respond to an urgent or emergency situation. During our inspection one of the GPs told our accompanying GP inspector they had dealt with a patient with an emergency physical health problem. They told us the patient had phoned the practice at 8.30am and reception had put them straight through to the GP. The GP saw them immediately and they were admitted to hospital within the hour.

Medicines management

The practice did not dispense its own medicines to patients. Patients could order their repeat prescriptions either via email, telephone, in person or by fax. The practice had a process which meant from when the patient requested a prescription to the prescription being sent to the pharmacy, the practice completed this within 24 hours.

One of the practice nurses told us they did not hold any controlled drugs. The medicines stocked were kept in a locked cupboard in a locked room outside the clinical rooms. The practice did not have a system to formally account for medicines which had been ordered or administered.

Medicines and vaccines which required storage in a refrigerator were within the safe temperature ranges and monitored regularly. The practice displayed signage above the refrigerator plug to advise staff to not unplug.

Prescription pads were held securely in a locked cupboard within the building. Stamped prescription pads were only used for home visits. All other prescription pads were left blank (no practice logo) and printed off with the practice log each time a patient was prescribed a prescription. Each GP would sign for each new prescription pad, to ensure accountability and responsibility for the pad. In use prescription pads were kept in doctors treatment rooms. Each treatment room was locked when left unattended.

Cleanliness and infection control

Patients were treated in a clean, hygienic environment. The inspection team saw throughout the inspection that areas of the practice appeared clean, tidy and free of items which may cause cross infection. Clinical areas of the surgeries had designated clinical spaces with surfaces which could be wiped clean. Each staff member was responsible for their own clinical room. Each room had a clean/dirty sink with elbow taps which showed good infection control practice. Appropriate personal protective equipment such as examination gloves and plastic protective aprons were available in these areas and were stored appropriately.

The practice nurse team leader had a lead responsibility for ensuring effective infection control throughout the practice. They had completed an infection control audit. One improvement noted was for training to be completed within the treatment room. We saw all nursing staff including health care assistants had received training to ensure effective hygiene practices were maintained.

Appropriate signage was available in patient and staff toilets that reminded staff and patients about good hygiene practices. All communal and non-clinical areas of the practice were maintained and cleaned routinely by the cleaning contractor. Bodily fluid kits were seen and staff told us they were aware of how to use them. Clinical waste bins had appropriate coloured liners that assisted in separating and disposing of waste safely. Clinical sharp objects such as needles were disposed of in recognised sealed containers and disposed of in line with current guidance.

The practice manager ensured the water taps that were not used regularly were flushed through each week. They recognised they had not had a formal risk assessment from a qualified professional which ensured the practice reduced the risk of legionella disease being contracted. The practice manager had previously arranged a risk assessment to be completed.

All nursing staff we spoke with knew how to deal with an infectious disease outbreak and which authorities they needed to report to. There have been no outbreaks of infectious diseases at the practice.

Are services safe?

Staffing and recruitment

The practice had relevant recruitment procedures in place that ensured staff were recruited appropriately. The majority of staff had been employed by the practice for a number of years. We saw two recruitment files from staff who had been employed most recently. The practice recruited staff and ensured they gained an employment history and two references from previous employers, where possible. The practice manager told us that staff were also interviewed for the role before they were offered the post. Written job offers were then made by the practice.

Before staff were appointed there was evidence that relevant checks had been made in relation to registration with their professional body and continuous professional development. Criminal background checks undertaken by the Disclosure and Barring Service (DBS) had been made for GPs and nursing staff. The practice had risk assessed administration staff to see if it was appropriate to check their criminal background depending on whether their job role involved working with vulnerable adults and children. However, they had not recorded this. The practice manager sent us evidence after the inspection to confirm they had now recorded a risk assessment for the administration staff role. We found proof of identification of prospective staff had not been taken prior to employment at the practice to ensure staff were who they said they were. The practice manager told us they would retain a copy of identification prior to staffs employment.

All staff went through a practice induction, some of which included; a tour of the practice, how to incident report, confidentiality and information sharing protocols, whether hepatitis B immunisation was applicable and the practice ethos.

Dealing with Emergencies

The practice had a proactive approach to anticipating potential patient safety risks. The practice manager told us if the practice had to close urgently then they had an agreement with other nearby practices for patients to be seen by them if in urgent need. If there was an electrical fault which caused a computer system failure then the practice had a backup server and each evening the reception staff printed off the patient list for the next day. If the telephone system failed then the practice had a one line back up that could still be used and GPs would use their mobile phones to call out to patients.

There were sufficient systems in place to deal with a medical emergency. The practice had oxygen, an automated external defibrillator and emergency medicines. Staff told us they felt confident to deal with a medical emergency. We saw they had regular cardiopulmonary resuscitation training once a year and the practice arranged two dates for staff to complete this training every year. Routine checks of this equipment were undertaken monthly by an allocated nursing staff member.

Equipment

The practice had systems in place to monitor the safety and effectiveness of equipment. For example, fridge temperatures were taken and recorded to show that correct storage temperatures were maintained for vaccines and medicines. Effective monthly checks were performed on oxygen, gases and the defibrillator. The practice manager ensured equipment, such as portable appliance testing, weighing scales, ECG, lift maintenance, burglar alarms, fire extinguishers and other equipment checks had been undertaken within appropriate timescales.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment in line with standards

Patients' care and treatment needs were assessed and care and treatment are delivered in line with current legislation, standards and guidance. The practice subscribed to a range of medical journals, publications and on line resources which provided and indicated recognised evidence-based practice. Each GP ensured they developed their knowledge and skills through a continuous professional development pathway. The GPs had their professional development checked during appraisal and revalidation; which took place every five years. The practice nurses completed a similar pathway and were supervised by the lead practice nurse.

We saw the practice was in routine receipt of the latest Medicines and Healthcare Products Regulatory Agency (MHRA) alerts which ensured effective treatment of patients. The practice received regular updates from the British National Formulary (BNF). This provided guidance and best practice about the safe use of medicines. This supported the effective treatment of patients.

Patients' capacity to consent was assessed in line with the Mental Capacity Act 2005 (MCA) and Gillick competence framework. The MCA is a framework which supports adults who need help to make decisions. The Gillick competence framework supports children who wish to make a decision without their parent or guardian present. Staff were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. For example, a best interest meeting had been arranged for a patient to decide if the patient, who lacked capacity, should have a flu vaccination. The practice had assessment of capacity forms, information on advocacy services and a policy for further guidance for staff. GPs were aware of consent issues for children and had access to a policy for child consent for clarification of the process.

Management, monitoring and improving outcomes for people

Patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease, were monitored throughout the year following an individual action plan. The action plan took into consideration factors such as, exercise, lifestyle, lowering cholesterol and monitoring blood pressure. Also, how the patient could take responsibility for their own care. The nursing staff coordinate annual check-ups and follow up any missed appointments with individual patients. In the meantime if the patient visits the GP, an alert is displayed on the patient screen, which enabled the GP to discuss with the patient about the missed appointment and any treatment they may have required.

The GPs had a weekly meeting to discuss patients who were likely to be admitted to hospital and if they could reduce the likeliness of a potential admission. The GP told our accompanying GP specialist advisor this was an important and effective part of their work.

Effective staffing, equipment and facilities

The practice had 29 staff including five GP partners, two salaried GPs, one trainee GP, four practice nurses, three health care assistants and 14 administration and reception staff. The practice had effective staffing and recruitment procedures in place to ensure clinical staff were recruited and supported appropriately.

Staff we spoke with told us they had annual appraisals. We saw evidence of discussions held in individual staff files. They showed areas for personal career development and praised good performance. The practice manager told us of examples of where a receptionist had been promoted to a health care assistant. The practice had provided the individuals support and training and enabled them to develop into this role.

The practice manager kept a running record of all training undertaken by all staff except the GP partners. This record highlighted when training was due and the practice manager raised this with the staff member or coordinated mandatory training for the whole practice, such as cardiopulmonary resuscitation training.

The practice manager told us they would arrange additional training for all staff in areas such as dementia, learning disabilities and end of life care. This ensured staff could develop their knowledge and increased their learning of specific patient needs.

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Are services effective?

(for example, treatment is effective)

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Working with other services

The practice had effective working arrangements with a range of other services such as, the community nursing team, the local authority, local nursing and residential services, the hospital consultants and a range of local and voluntary groups.

Health visitors were based on the practice site and this enabled clear communication between them and practice staff. The practice was involved in various multidisciplinary weekly meetings involving palliative care nurse, health visitors, social workers and district nurses to discuss vulnerable patients at risk and with complex health needs and how they reduced hospital admissions. The lead GP for safeguarding children attended a weekly child protection meeting with the local midwife and health visitors. This enabled the practice to have a multidisciplinary approach which ensured each patient received the appropriate level of care.

The practice ensured the out of hours and emergency services were provided with special notes where a patient had complex health needs and was likely to contact the out of hours or call the emergency services. The practice could leave a special notes for the service so they were aware of the patients' needs.

Health, promotion and prevention

All new patients over the age of five years old were asked to book an appointment for a health check with the GP when they register with the practice. The health check consists of a blood pressure check, height and weight check and a urine sample. All new patients completed a new patient questionnaire which asked patients for their past medical and family histories and social factors such as occupation and lifestyle.

A range of information and health promotion leaflets were available in the waiting areas of the practice. There were sexual health leaflets displayed in the patient toilets and encouraged patients under the age of 25 years to take a sexual health screening test.

The practice website provided further information and advice to patients who maybe suffering from minor illnesses such as colds and flu, sore throats and diarrhoea and vomiting. The website also included information on why patients would need attend accident and emergency and why patients would be prescribed antibiotics.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice was purpose built and had amenities to enable all patients to easily access the practice. This included a lift (because the practice was on the first and second floor of the building), facilities for disabled patients, there was a hearing loop available for patients who were hard of hearing and a translation service was available for patients who did not have English as their first language. The reception area was set away from the three waiting areas and part of the desk had been lowered for ease of access for wheelchair users and children. The practice had a separate room for patients to discuss confidential matters away from the reception desk. This room was always kept free for patients and there was a sign advertising this in the reception area. We observed receptionists transferring calls to other staff in the practice to protect their identity from patients in the reception area and they used the patient code number to protect their confidentiality.

The patients we spoke with told us about the excellent levels of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. A patient told us that when their partner had received end of life care, their GP visited them on a number of occasions (without an appointment) during this time to check if everything was ok. This showed the patient that the GP had a great deal of empathy towards the situation and the patient. The GPs also support bereaved relatives and ensured they contacted the relative three months after the patient had passed away. This enabled the GP to show compassion and also respected that the relative may not want to be contacted straight away.

Patients were greeted in their preferred manner and conditions were not discussed in a way which could undermine their privacy. We observed there were curtains and blinds in the treatment rooms, this provided patients with privacy and dignity when receiving intimate or personal care. Also, the treatment room door was lockable and we observed treatment room rooms being locked throughout our visit. Staff told us the importance of not rushing patients and giving patients time to talk.

One of the GPs formed the group which started in 1978. This is a charity which provided a voluntary service for transport to GP or hospital appointments, social activities, support and information to the elderly, frail and sick patients of Pembroke House Surgery and the local area. The practice had an active involvement in supporting the service and met with them regularly to discuss new ideas and how to best meet the needs of the patients in the area.

The practice manager told us that if any disrespectful, discriminatory, abusive or poor attitudes from staff were observed then they would expect this to be reported to their line manager and possible disciplinary action would be taken.

The practice offered a chaperone service. A chaperone is a member of staff who acts as a witness for a GP or nursing staff and a patient during a medical examination or treatment. This service was provided by one of the nursing team on request of a GP or nurse, if a patient wished this. There was never any need to use a receptionist because there was always a duty nurse or GP available to assist with any requests. The practice advertised this service to patients in the waiting areas of the practice. GPs and nursing staff asked the patient if they wanted a chaperone when appropriate.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they have sufficient time to discuss their concerns with their GP. The new appointment system enabled the patient to discuss their concern on the telephone with the GP. The GP would then determine how much time the patient needed for their appointment. For example, patients with long term conditions were allocated a longer appointment time slot depending on their need. A patient told us they had a discussion with the GP about their treatment options and they had disagreed with the GP. They told us the GP respected their decision and supported them to make their own choice.

Patients were supported to understand the assessment process, any diagnosis given and their options for care and treatment. A patient told us they were given information leaflets about any potential treatment to aid their understanding of the treatment provided. Patients decided who they wanted involved in their care. A patient told us their wife was involved in their care and was welcomed by

Are services caring?

the GP in consultations with their partner. The practice had a system in place to identify patients where they wanted their partners or family involved in their care and decision making.

Patients were communicated with in a way that they understood and was appropriate and respectful. The practice had used an interpretation service for patients where English was not their first language. Patients who had a learning disability were sent information, such as their annual health check, in an easy read format (a document of pictures, symbols and simple words). The practice told us they would arrange training awareness for staff on dementia awareness, learning disabilities and end of life care, from the perspective of the patient. This could develop further learning and understanding of patient communication.

Decisions about or on behalf of patients lacking mental capacity to consent to their treatment decisions were made in the patients' best interest in accordance with the Mental Capacity Act 2005 and Gillick competence framework. The MCA is a framework which supports adults who need help to make decisions. The Gillick competence framework supports children who wish to make a decision without their parent or guardian present. Staff were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. For example, a best interest meeting had been arranged for a patient to decide if the patient, who lacked capacity, should have a flu vaccination. The practice had assessment of capacity forms, information on advocacy services and a policy for further guidance for staff. GPs were aware of consent issues for children and had access to a policy for child consent for clarification of the process.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it serves and acted on these to design services. The practice had established a patient panel to help understand patient needs. The group was made up of 30 representatives from a sample of patients who received care and treatment from the practice. This included a young mother, patients from the working population, patients with long term conditions and patients over 75 years. The practice had worked with the group when making decisions about the service that may have an impact on patients; such as when the practice changed how patients would make their appointments. The practice gained 271 patient and staff views, through an annual patient survey in 2013. The survey concluded that 87% of views were good, very good or excellent about the care and treatment provided. Main areas for improvement were telephone access. This confirmed the practice decision to implement a new appointment system to improve patient experience.

The practice actively engaged with commissioners of services, local authorities and other health care professionals to provide coordinated and integrated pathways of care that met patients' needs. Health visitors were based on the practice site and this enabled good communication between them and practice staff. The practice was involved in various multidisciplinary weekly meetings which involved palliative care nurse, health visitors, social workers and district nurses. They discussed vulnerable patients who might be at risk and had complex health needs and how they reduced hospital admissions. The lead GP for safeguarding children attended a weekly child protection meeting with the local midwife and health visitors.

The practice supported patients to have a choice of being seen by a male or female GP by ensuring there is a male or female GP on duty Monday to Friday. The rota system for annual leave ensured only one male or female GP could be off at any one time. Patients told us they had a choice to see a male or female GP. One patient said they wanted to see a female GP and said they were given an appointment with a female GP. They said if they had to see a male GP they thought they would not be able to tell them their problem.

The practice encouraged personal continuity of care with their GP. Patients over 75 years all had an allocated GP. The practice manager told us that the practice tried to ensure patients were allocated appointments with their preferred or allocated GP.

The practice ensured there were a range of appropriate service provision to meet patients needs. This included capacity for appointments and services. Patients were asked in a recent practice survey what times of appointments they preferred; either later evening or Saturdays appointments. Patients unanimously chose Saturday appointments. The practice had now implemented a Saturday GP clinic for patients.

Patients being referred to hospital were supported to choose a hospital or service that met their preference. A patient told us they felt supported when they were referred to hospital and supported in this process by the GP. They told us the practice had good links between the hospital and practice which enabled swift referrals.

Access to the service

There was an easy to use appointment system, which supports patient choice and enabled the patients to access the right care at the right time. The practice implemented a new appointment system on 31 March 2014. Each patient that rang for an appointment told the receptionist a brief description of the presenting problem and how urgent it was. The message was passed through to a duty GP who then prioritises the call. This enabled them to assess whether the person needed to either discuss the problem on the phone, receive a home visit or required an appointment in the practice. All GPs had at least 60% of their appointments free each day for allocating appointments. The practice manager told us this had enabled the practice to allocate an appropriate time length for appointments, deal with patient problems over the phone and see patients more promptly for urgent needs. For example, one of the GPs told us they spoke with a patient at 8:30am, saw them immediately because their presenting problem was urgent and then arranged for them to be admitted to hospital within the hour because of the nature of their diagnosis.

Are services responsive to people's needs?

(for example, to feedback?)

Patients who requested an appointment on the same day were guaranteed to receive one. Patients were able to book appointment by telephone or the practice online appointment service. The practice had at least three staff answering the telephone and the receptionists took calls from patients when the dedicated staff were busy. The practice opening hours were clearly displayed in the practice and on their website and patient information leaflet. If patients required GP assistance out of practice hours then details of who to contact were clearly displayed in the practice, on their website and in the practice information leaflet.

Patients were able to pre-book appointments but only for an appropriate reason. For example, to follow up on test results, if the GP had requested one or if the patient found it difficult to book an appointment, such as because of their working hours.

The practice supported patients to receive a timely and accurate diagnosis, either directly from the practice or by referral to an appropriate specialist. For example, a GP told our accompanying GP specialist advisor, a patient who had been experiencing a mental health crisis had been referred to hospital for an urgent mental health assessment.

Patients told us they were happy with the appointment system. They made and contacted the practice easily for an appointment, were given an appointment when needed and often saw their doctor of choice. Patients said they never had to wait long to be seen by the GP and were informed if there was a delay. On the day of our inspection, we saw patients had their appointment at the correct time.

Concerns and complaints

Patients knew how to raise concerns or make a complaint. The practice complaints procedure was promoted on the patient notice board, in the practice's brochure and on their website. From patient feedback we saw patients were very satisfied with the service received.

The practice complaints procedure detailed how patients could complain and what they could expect. If they were unsatisfied with how the practice had dealt with the complaint, details of how to escalate their complaint through the relevant authorities was explained.

The practice continuously reviewed and acted on information about the quality of care received by patients. We saw the practice had received nine complaints from April to March 2014. The practice manager had analysed the complaints and had discussed them in a team meeting. This enabled learning points to be raised and identified how any changes to practice would be embedded.

The practice patient panel patient representatives were positive with staffs' open and honest participation in their meetings and were confident that their feedback would influence how the practice was run.

Are services well-led?

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

Our findings

Leadership and culture

The practice had clear vision and values which stated providing patients with high quality care was a top priority. Staff told us about the practice values and we heard and saw examples of compassion, dignity, respect and equality towards patients throughout our inspection. The staff induction encompassed the practice ethos and ensured new staff displayed the values and vision as described in the practice statement of purpose.

The practice had a strategy to continuously improve patient care and treatment. The partners arranged an annual weekend away. They discussed the practice objectives, what they needed to do to achieve them and created clear objectives to develop the practice further. The partners also discussed how they could improve patient outcomes. For example, they agreed that after a bank holiday weekend they would implement full staffing ratios as if it was a Monday because this tended to busier than a normal Tuesday.

It was evident throughout our inspection that the management team encouraged cooperative, appreciative and supportive relationships amongst staff teams and support services. Staff told us they felt supported, valued and motivated. We observed staff willing to help others and work as team throughout our inspection. For example, the reception team leader supported reception when a receptionist left for the day to ensure there was adequate cover.

Governance arrangements

Governance arrangements were effective and supported transparency and openness. We saw the provider had a range of governance policies and protocols that covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance.

Staff were clear about what decisions they were required to make, what they were responsible for and the limits of their authority. Staff described situations of when they would need to refer specific decisions to another member of staff. For example, staff who were concerned about a child would go to the safeguarding lead for child protection. Staff who had an infection control concern would go to the infection control lead. Practice policies clearly provided the lines of authority for staff to follow. Staff were sent email updates that ensured all staff were up to date with the practice policies, if they were changed.

Regular meetings were held in the practice for all staff which ensured staff were updated and aware of who was responsible for decisions around provision, safety and adequacy of care provided. Meetings were held for all teams including administrators, team leaders and management, GPs and nursing staff. An all staff meeting was held for half an hour each week. Discussions were held about day to day running of the departments, any updates on guidance and improvements to patient care. Our accompanying GP specialist advisor spoke with a GP who told us the clinical governance meetings discussed significant incidents, complaints, interesting/complex cases and feedback from educational activities.

Systems to monitor and improve quality and improvement (leadership)

The practice carried out regular clinical audits of how treatment and care was provided. For example, we heard that an antibiotic prescribing audit had been carried out. The antibiotic prescribing audit was effective because it identified the rate of prescribing across the practice. This resulted in reduced prescribing within the practice due to the clinical team having discussed the results and the related guidance and how they could reduce prescribing of antibiotics. A chronic obstructive pulmonary disease (COPD) audit was carried out by the practice to identify how high hospital admissions were for patients with this condition. The audit identified that hospital admissions were high and needed to be reduced. A COPD nurse attended the practice to provide additional training to clinical staff to help identify alternative treatments for patients. This had significantly reduced the amount of patient admissions to hospital because staff knowledge and the treatment provided had been improved.

The practice carried out an analysis on patients who were likely to be admitted to hospital in the next 12 months. If they were assessed as being at risk then a support plan was agreed with the patient. For example, where they had a specific need such as COPD. Patients were allocated a key person to contact in the practice. For example, a respiratory nurse. The outcome for the practice was reduced admissions to hospital and an advanced service to patients.

Are services well-led?

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

Patient experience and involvement

Patients spoke highly of the service and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. The practice had established a patient panel which was used to inform the practice development. The practice continuously strived to improve the patient panel membership. All new patients were asked if they would like to join via completing the patient questionnaire. Information was displayed about the patient panel on both the practice website and in the practice. Patients from the panel told us they felt their involvement was valued. All patients we spoke with or heard from spoke about the excellent service they received from all staff.

An annual patient survey was taken to ask patients what they thought about the service provided, such as practice access, respect for privacy and confidentiality, encouraging self-care and ability of staff to listen to the patient. The practice scored highly overall with 87% satisfaction with the service provided of the 271 patients surveyed.

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

The voices of staff were encouraged, heard and action upon. The practice manager had an open door policy. Staff told us they felt able to raise concerns either with the staff member involved or through their line management. The practice manager gave us examples of when staff had approached them and raised a concern. They told us they had dealt with the concern sensitively with the members of staff involved.

Staff meetings provided an open environment to raise concerns. For example, administration staff told us they felt able to raise concerns in front of the clinical staff. Staff spoke of practice staff who worked as a team, knew how each role had its own importance and how they needed to work together to provide good outcomes for patients.

Management lead through learning and improvement

The practice had systems in place to enable learning and improve performance. The practice involved patients, staff and other services/professionals when they considered how to improve the service provided.

The practice had made a number of significant changes recently. This included implementing a new appointment system which guaranteed patients would see their GP the same day if needed. The practice updated their patient record computer system, to enable GPs and nursing staff to access important information about the patient easily and provided the ability to send text reminders to patients for appointments. The practice moved sites to a purpose built building to better meet patients needs, such as improved accessibility for patients. The practice changed the process of prescribing medicines to electronic prescriptions to enable patients to choose what pharmacy they could collect their prescriptions from and receive their prescription within a shorter timescale.

Identification and management of risk

The practice regularly assessed risks to the practice. This included reviewing significant events, complaints from patients and reviewing patient risks through multidisciplinary meetings. For example, on one occasion there had been a prescription error and the wrong medicine was prescribed for the patient. The practice decided they would discuss learning with the pharmacy involved. As a team incidents were discussed and action taken where needed to provide overall improvements to the practice.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a higher than national England average older patient population. 15% of registered patients were over 75 years old equating to 1536 patients and 36% were over the age of 60 years old. Each patient over the age of 75 years old was allocated a specific GP as their point of contact. This GP would take the overall responsibility for meeting the patients needs. The practice had allocated GPs to patients who they had seen the most to ensure consistency of care.

The practice had patients who were residents at local care homes and nursing homes. GPs were not allocated individual homes. The practice manager informed us they had recently had a multidisciplinary meeting to discuss integrating care with the care homes in the area. The plan was to decide on the benefits and negatives of allocating a specific GP practice to the individual care home to improve efficiency and patient care.

The practice had hearing loop facilities for the hard of hearing and had facilities for patients with disabilities.

The patient panel was represented by four patients who were over 75 years old. This ensured a range of population group views were provided to the practice.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

Patients with long term conditions, such as diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD), were monitored throughout the year following an individual action plan. The action plan took into consideration factors such as, exercise, lifestyle, lowering cholesterol and monitoring blood pressure. It also included, how the patient would take responsibility for their own care. The nursing staff coordinated annual check-ups and followed up any missed appointments with individual patients.

The practice recognised that admissions to hospital for patients with COPD were higher than they liked. They arranged for a COPD nurse to attend the practice to provide additional training to the practice nurses. This had reduced the amount of admissions to hospital for these patients.

The practice manager informed us 1% of patients registered at the practice were diagnosed with a dementia and a number of patients were recognised to have short term memory loss. The practice was considering a session of staff to discuss dementia in order to improve learning and knowledge of dementia for all staff.

The practice had a weekly multidisciplinary meeting with other professionals such as social workers, palliative care nurses, district nurses and health visitors to discuss vulnerable patients. The purpose of the meeting was to ensure there was an integrated care approach to patients with complex health care needs so they received the best care possible. The meetings also highlighted patients who were likely to be admitted to hospital in the near future and how to reduce this possibility, such as increasing community care support for the patient.

The practice strived to improve outcomes for patients who were receiving end of life care. The practice followed the gold standards framework which improved care and treatment for patients who were receiving end of life care.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice offered many services for mothers and babies. This included a baby clinic once a week and antenatal classes within the practice. Midwives attended the practice twice a week on a Tuesday and Friday. They would provide advice to expectant mothers throughout their pregnancy. Health visitors were based in the practice during normal working hours. Health visitors provide advice and checks for mothers and babies after the baby was born. The practice provided child immunisations by the practice nurses. We saw training for nurses for the administering of immunisations and vaccines were completed annually.

Regular weekly meetings were held with a GP, midwife and health visitors to discuss any patients who were at risk. This ensured there was clear communication between the health care professionals which also ensured risks were assessed and reduced for mother and baby.

The practice was equipped to welcome children and babies into the practice. We saw toys in the waiting area and in each treatment room there was a small table and chairs with activities which entertained children.

One GP told our accompanying GP that they planned to complete care plans for children with special educational needs. This would identify any additional health care needs they may need including any annual health check-ups.

There was one member of the patient panel who was a student and one member who was a mother of a young person. This ensured a range of population group views were provided to the practice.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice met the working age population needs by increased ease of access to make appointments by offering an online service. The patient could note online the most suitable time for the GP to phone them back to avoid workplace inconvenience. We were told the GP would try to fit in with the patient needs. GPs had pre-bookable appointments for patients who found it difficult to visit the practice at short notice due to work commitments.

The practice had extended its opening hours from 8am to 6pm Monday to Friday and opened Saturdays from 8am to 12:45pm, where a GP was always available. There was always a practice nurse working from 8am to 6pm Monday to Friday to carry out diagnostic tests such as blood tests. The practice nurse was unable to attend on a Saturday for diagnostic tests, such as blood tests, because the samples taken could not be collected until the Monday morning, which meant samples could deteriorate if left for that period.

There were eight members of the patient panel were in employment and 13 members were retired under the age of 74 years old that represented the group. This ensured a range of population group views were provided to the practice.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

Information from the practice website showed the practice was based in a low deprivation area. There were also a low number of patients whose ethnicity was not white British – 0.1% of patients. The practice manager informed us there was a homeless centre situated centrally in the area where another practice regularly carried out clinics. There was no traveller community nearby.

The practice had 69 patients registered with them who had been diagnosed with a learning disability. The practice had patients registered from local learning disability care homes and supported living homes. Patients with a learning disability were asked to attend an annual health check in line with national guidance. 88% of 69 patients had received an annual health check in the last year. The practice nurses tried to encourage attendance for these checks by sending reminders and contacting the patient by telephone. The practice liaised with the local learning disability nurse to ensure that where risks were identified they were communicated with appropriate professionals.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice had 100 patients who were experiencing a mental health problem. The practice assessed patients with mental health problems to see if a care plan was necessary. Eighty-seven patients had been assessed as requiring a care plan and 91% had been completed. Care plans ensured appropriate plans and risk assessments were in place and ensured the patient was appropriately cared for by the appropriate health care professionals at the right time. The practice also asked patients to attend an annual check-up, this reviewed health checks such as, blood pressure, alcohol intake monitoring, cervical smear checks and a medicines review.

The practice worked closely with the local mental health crisis team. We heard of an example where a GP had referral a patient who had been identified as having been at risk of experiencing a mental health problem to the local crisis team on the day of our inspection. The practice also attended multidisciplinary meetings to discuss particular patients at risk. Action plans were developed to ensure there was protection for both patients and staff.

Where possible the practice tried to ensure the patient saw the same GP for continuity of care.

Where the practice was based, there was also a facility in the building for patients to receive counselling for anxiety or depression provided by the Devon Partnership Trust. This was based on referrals only. The practice manager told us they linked closely with the Trust to ensure there was good communication between the GPs and the counselling service.