South Brent Health Centre

Quality Report

Plymouth Road
South Brent
TQ10 9HT
Tel: 01364 72394
Website: www.southbrenthealth.co.uk

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

Ratings

Overall rating for this service	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 South Brent on 4 April 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice was in the process of introducing a policy which identified military veterans in line with the Armed Forces Covenant 2014. This was planned for completion in May 2017. This policy would enable priority access to secondary care to be provided for those patients with conditions arising from their service to their country.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and 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 evidence from four examples reviewed showed 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 to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.

Summary of findings

- The provider was aware of the requirements of the duty of candour. We saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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

Good

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. GPs from the practice visited two residential care homes on a weekly basis and shared information appropriately regarding these patients.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes on the register, who had achieved an average blood sugar level in the last 12 months was 84%, which was better than the clinical commissioning group average of 81% and the national average of 78%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Summary of findings

- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital, including signposting to support services such as health visitors. Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

Good

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and Saturday appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

- The practice carried out advance care planning for patients living with dementia.
- 80% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 83%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia, by signposting patients to relevant mental health and dementia services and providing appropriate care planning.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 95% which was the same as the clinical commissioning group and national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.

Summary of findings

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

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2017. The results showed the practice was performing in line with local and national averages. 215 survey forms were distributed and 110 were returned. This represented 2% of the practice's patient list.

- 97% of patients described the overall experience of this GP practice as good compared with the CCG average of 90% and the national average of 85%.
- 95% of patients described their experience of making an appointment as good compared with the CCG average of 83% and the national average of 73%.
- 96% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards which were all positive about the standard of care received. Patients described the kind and caring professional approach of the GPs and nurses. Patients also wrote about the helpful receptionist team and the clean well organised environment.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Over the last 12 months the practice had received 58 responses for the NHS Friends and Family survey. Of these, 96% said that they were likely or extremely likely to recommend the service to their friends and family.

South Brent Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to South Brent Health Centre

South Brent Health Centre practice is situated in South Brent in the rural area of the South Hams in Devon.

The deprivation decile rating for this area is seven (with one being the most deprived and 10 being the least deprived). The practice provides a primary medical service to approximately 5,289 patients of a diverse age group. The 2011 census data showed that majority of the local population identified themselves as being White British. Public health data showed 3.7% of the patients are aged over 85 years old which is higher than the local average (CCG) of 3.1% and higher than the national average of 2.3%.

There is a team of five GPs partners, two female and three male. Four GPs worked part time and one worked full time making the whole time equivalent almost 3.4 WTE. Partners hold managerial and financial responsibility for running the business. The GP team were supported by a practice manager, deputy practice manager, a nurse prescriber, three practice nurses, three health care assistant, and additional administration staff.

Patients using the practice also have access to community nurses, mental health teams, drug and alcohol counsellors, retinal screening service, midwives and health visitors, chiropodists, podiatrists and physiotherapists who used rooms at this rural practice on a regular basis.

The practice is open between the NHS contracted opening hours 8am and 6pm Monday to Friday. Appointments are offered anytime within these hours. Extended hours are worked on Saturdays from 8.30am until 11am. Between 6pm to 6.30pm and at all other times, patients are directed to contact the out of hours service and the NHS 111 number.

The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments as well as online services such as repeat prescriptions.

The practice has a General Medical Services (GMS) contract with NHS England.

This report relates to the regulatory activities being carried out at:

South Brent Health Centre, Plymouth Road, South Brent TQ10 9HT.

We visited this location during our inspection.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as Healthwatch, to share what they knew. We carried out an announced visit on 4 April 2017. During our visit we:

- Spoke with a range of staff including the practice manager, deputy practice manager, receptionists, three GPs and two nurses and spoke with four patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed 36 comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of eight documented examples over the last 12 months, we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an incident occurred where the wrong patient was booked into see a GP. The GP had the wrong patient's details on their screen during the consultation. The GP issued the patient with a prescription and the error came to light when the patient presented the prescription to the independent pharmacist in the village. The incident highlighted the need for a more robust system for checking dates of birth and addresses prior to confirming the appointment. This was introduced immediately. Shared learning took place with the staff, the CCG (clinical commissioning group) and NHS England. The patient was contacted and an apology was made. The patient was satisfied with the outcome.
- The practice also monitored trends in significant events and evaluated any action taken. For example, the practice held development afternoons at GP meetings. GP meetings took place every Monday. Agenda items included significant events, including the actions taken following the event described above. The practice manager maintained a spreadsheet of every significant event since 2014 which was on a shared computer system which all staff could access.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of four documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. The GP safeguarding lead joined multidisciplinary safeguarding meetings on a quarterly basis.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses had received safeguarding training level two.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). All other staff at the practice had received a DBS check, which was practice policy and was designed to support patient safety.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had

received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The most recent IPC audit had taken place on 27 March 2017. Identified actions included the inclusion of cleaning children's toys in the cleaning schedules.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from a GP for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available with a nominated representative. A poster displayed these details in reception. The policy had been reviewed in March 2017.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. The practice had a professional contractor to carry out fire alarm, emergency lighting and system checks.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. This last took place in November 2016 and was planned to be repeated every two years in line with current practice.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice used a professional contractor to carry out these checks.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice management monitored the staffing levels on a daily basis and made adjustments in line with patient demand and staff availability.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

Good

Are services safe?

- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. This had been reviewed in November 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.6% of the total number of points available compared with the clinical commissioning group (CCG) average of 95.8% and national average of 95.3%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015-2016 showed:

- The percentage of patients with diabetes on the register, who had achieved an average blood sugar level in the last 12 months, was 84%, which was better than the clinical commissioning group average of 81% and the national average of 78%.
- The percentage of patients with physical and/or mental health conditions whose notes recorded smoking status in the preceding 12 months was 95% which was the same as the clinical commissioning group and national average.

There was evidence of quality improvement including clinical audit:

- There had been six clinical audits commenced in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, prescribing audits on antibiotics had identified patients who had been prescribed antibiotics which were due for review. Dosages and types of medicines were adjusted as a result. Patients benefitted as they were no longer exposed to the side effects of taking multiple medicines.
- An audit had taken place on patients who had their spleen removed through surgery. This complete cycle audit examined the treatment of these patients and its effectiveness post-surgery. Actions identified and carried out as a result of the audit included the changing of medicine dosages where appropriate.

Information about patients' outcomes was used to make improvements such as: an audit on the recording of patient's cholesterol levels had been undertaken. This had identified the need for measuring cholesterol levels in patients in at risk groups, such as those with long term conditions. The audit had resulted in raised awareness of the importance of monitoring cholesterol and its potential impact on patient health.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The nurses attended Plymouth Nurses Forum on a bi monthly basis which included statutory training and courses on diabetic care. The nurses we spoke with told us they had a strong support network for role specific training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice

development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of four documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example, when referring patients to other services. The practice used a computer system called AdAstra to share relevant patient information with the out of hours service and the ambulance service. The practice also emailed patient summaries to hospitals on admittance.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Counsellors providing advice on alcohol and drug addiction visited the practice on a regular basis.
- A dietician was available via referral to a local hospital and smoking cessation advice was available from an adviser based at the practice. The practice had links with a local walking group and could refer patients to this. GPs could refer patients to a local gym through a local scheme.

The practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 82% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 92% to 93% and five year olds from 90% to 93%. This was comparable with national averages of 90% and 88% respectively.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There

Good

Are services effective?

(for example, treatment is effective)

were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included the planned re-introduction of NHS health checks for patients aged 40–74 years in May 2017. The practice provided health checks for all new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified, were also planned.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 36 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four patients including two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 94% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 87%.
- 96% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 92%
- 99% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 95% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 96% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 99% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 92% of patients said they found the receptionists at the practice helpful compared with the CCG average of 90% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, the staff of the two local residential care homes where some of the practice's patients lived praised the care provided by the practice. Where a concern had been identified, the practice had acted upon it promptly in line with recognised guidance. Each residential care home had a nominated GP who visited patients each week.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals. The practice advertised the youth advisory scheme in nearby Ivybridge, together with providing chlamydia screening at the practice. The practice provided signposting information on support services available for eating disorders.

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

Good

Are services caring?

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 98% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service had been replaced with another national electronic referral service which gave patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1.75% patients of the practice list of 5,289 as carers. The practice used the opportunity of flu vaccination clinics to identify carers. The practice offered dedicated flu clinics for carers, referrals to South Brent Caring, Care Direct and carer's health checks. The practice could refer occupational health to visit patient's homes to provide an assessment of carer's and patient's needs. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Members of staff acted as carers' champions to help ensure that the various services supporting carers were co-ordinated and effective.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. GPs also made contact a month after the bereavement to check on the family's needs and offer ongoing support.

The practice planned to introduce a policy to identify military veterans in line with the Armed Forces Covenant 2014 by May 2017. This would enable priority access to secondary care to be provided to those patients with conditions arising from their service to their country.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Saturday mornings for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS. For all other travel vaccines patients were referred to a travel clinic.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had a chairlift to access the first floor. All patient facing services were on the ground floor.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice had considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients received information in formats that they can understood and received appropriate support to help them to communicate effectively with staff.

Access to the service

The practice was open between the NHS contracted opening hours 8am and 6pm Monday to Friday. Appointments are offered anytime within these hours.

Extended hours were provided on Saturdays from 8.30am until 11am. Between 6pm to 6.30pm and at all other times outside those listed above, patients were directed to contact the out of hours service and the NHS 111 number.

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

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

- 86% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 98% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 90% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 85% and the national average of 76%.
- 100% of patients said their last appointment was convenient compared with the CCG average of 95% and the national average of 92%.
- 95% of patients described their experience of making an appointment as good compared with the CCG average of 83% and the national average of 73%.
- 78% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 64% and the national average of 58%.

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

The practice had a system to assess:

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

Every day a list was generated on the practice home visit appointment system. Staff printed off a patient summary and provided it to the duty on call GP, or the named GP if they are on duty that day. GPs then assessed each case individually, gathered information for example, by telephoning the patient or carer in advance to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait

Good

Are services responsive to people's needs?

(for example, to feedback?)

for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a poster displayed at reception which explained how to make a complaint should a patient wish to do so.

We looked at four complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

For example, one morning a patient had visited the practice at 11.20am and demanded they be seen immediately to check a wound. Receptionists explained that emergencies needed to be treated at a minor injuries unit or hospital, the nearest being Totness hospital or Ivybridge health centre. The patient refused to do this. The practice offered the patient the next available appointment, which was in the afternoon. The patient became distressed and was spoken with in person by the practice manager who provided them with appropriate treatment options. A GP broke off from seeing another patient, saw the complainant, and referred them to the nearest hospital. The patient was driven to the hospital. The practice carried out shared learning including with staff and NHS England. The practice provided a written response to the patient and offered a follow up face to face meeting. The patient was satisfied with the outcome. Staff shared learning included the decision of GPs that they should be immediately notified of any similar future incidents at the practice as they arose.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a statement of purpose, which was displayed on the website, in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, safeguarding, chronic disease management, dementia, mental health and respiratory care. There were leads for staffing, finance, and health and safety.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Staff development afternoons were held, which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, legionella checks and infection prevention control audits.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings. The practice held CCG funded development afternoons twice a year which covered such areas as CPR training. The practice also held all staff meetings twice a year. The practice held nurses and HCAs meetings fortnightly, administration staff every six weeks and GP meetings every Monday afternoon. Business meetings took place every six weeks.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the patient participation group (PPG) and through surveys and complaints received.
- The PPG had proposed opening hours be amended to the opening hours to a Saturday morning, this had been adopted by the practice. It was practice policy that very early in the morning appointments should be reserved for those in employment. The PPG had 12 members and utilised online communication, or by telephone.
- We spoke with two members of the PPG. PPG views of the practice were very positive. Patients said that the staff were friendly, professional and a high quality of care was delivered by the service. One patient who was a wheelchair user told us they found the service was very accessible. Patient facing services were all on the ground floor and that the automatic doors at the front were useful. There was allocated disabled parking. The practice GPs were described as being very positive and forward thinking.
- The practice participated in the national NHS Friends and Family survey. Over the last 12 months the practice had received 58 responses. Of these, 96% said that they were likely or extremely likely to recommend the service to their friends and family.
- The practice kept up to date with staff feedback through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management add your own examples of where the practice had listened to staff feedback. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was both a teaching practice and a training practice, supporting both medical students and trainee GPs. The practice had two qualified GP trainers supporting two GP registrars. The practice had supported 12 medical students in the last 12 months.

GPs kept themselves up to date with the latest developments through participation on the Local Medical Committee (LMC) and tutoring at the Peninsula Medical School.