Mid Devon Medical Practice

Quality Report

Witheridge Medical Centre
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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?	Requires improvement
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

Mid Devon Medical Practice was inspected on Monday 27 October 2014. This was a comprehensive inspection covering the main location at Witheridge and two branch surgeries.

Mid Devon Medical Practice provides primary medical services to people living in Witheridge and surrounding villages in Devon covering approximately 300 square miles. The practice consists of three GP surgeries based at Witheridge, Morchard Bishop and Cheriton Fitzpane. All three surgeries have dispensaries, which we inspected on the same day.

The practice provides services to a diverse population. At the time of our inspection there were approximately 5,000 patients registered at the service with a team of three GP partners. GP partners held managerial and financial responsibility for running the business.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice is rated as GOOD. Our key findings were as follows:

- Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients.
- Feedback we received from patients about their care and treatment was consistently positive. The culture of the practice was patient centred. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and were aligned with our findings.

Summary of findings

- The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.
- Information received about the practice prior to and during the inspection demonstrated the practice performed comparatively and in some instances better when compared with all other practices within the clinical commissioning group (CCG) area. These areas included cervical screening for women with complex mental health needs and annual health checks of patients with a learning disability.

We saw several areas of outstanding practice including:

- The care and treatment of patients with long term conditions at the practice was effective. There were several examples of latest developments and equipment being used to treat people, which resulted in early diagnosis and a more responsive approach to treatment. Research carried out by one of the GP partners had led to patients benefitting from increased knowledge, early diagnosis and more accurate monitoring of hypertension. As a result, patients with early signs of potential long term conditions which put them at risk of strokes were detected and commenced treatment sooner.
- The service was responsive and compassionate with patients who had mental health needs. Staff were innovative in the way they engaged with patients with complex mental health needs. As a result, the practice was performing better when compared nationally with regard to health screening for vulnerable groups of people.
- The involvement in a pilot scheme and continued use of a centrifuge had increased the lifespan of blood samples so that patients did not have to travel for up to five hours on public transport to the local hospital.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that repeat prescriptions are signed by a GP before the medicines are given to the patient.
- Review how controlled drugs are handled to ensure that the standard operating procedures are followed.

In addition the provider should:

- Record the audits of infection control arrangements to demonstrate that learning and actions have led to sustained change and provide assurance of risk management.
- Consider other options, such as a virtual patient participation group (PPG) to engage patients in the on-going development of the service.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services, as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated to support improvement. Risks to patients who used services were assessed and systems and processes to address these risks were mostly implemented to ensure patients were kept safe. Infection control arrangements had been audited, but the practice was unable to show whether improvements were effective and sustained. We identified potential risks with regard to the procedures followed for repeat prescriptions dispensed to patients. The practice managed the complex needs of patients well and responded in a timely way when urgent care and treatment was required.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were not only up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines, but evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients. Data that showed that the practice was performing highly in a number of areas when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and had links with other local providers to share best practice. For example, academic research carried out by a GP at the practice in conjunction with a local university had further developed healthcare professionals knowledge about early diagnosis of hypertension and reduction of risk associated with this condition. Patients with long term conditions received outstanding care and treatment that was based on leading research knowledge.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for some aspects of care. Twenty nine CQC comments cards reviewed and discussion with eight patients on the day all provided positive feedback. A common theme was that the staff were extremely person-centred and patients were always treated with respect and compassion. This was borne out in the way staff engaged with

Summary of findings

patients with complex communication needs. Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them. Patients with mental health needs received outstanding compassionate care, which engaged them and their carers in making decisions about the care and support they needed.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients reported good access, including same day routine appointments with a named GP and continuity of care. Urgent appointments were also available the same day. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with staff and other stakeholders. Improvements as a result of the learning from complaints included greater awareness of the importance of handling sensitive information. Patients with mental health needs experienced an outstanding service of early interventions responding to emerging risks which helped to reduce hospital admissions.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice had tried to set up a patient participation group (PPG) but had been unsuccessful due to lack of interest, which was thought to be down to the challenges of a rural location with limited transport links. Arrangements were in place to start obtaining daily feedback from patients for the 'Friends and Family Test'. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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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.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits. Older patients newly discharged from hospital were contacted within three days to check on their well being. Social isolation was recognised as a risk for older people and the practice worked closely with local charities and other agencies to provide additional support to improve the quality of life for people. For example, patients were signposted to walking and lunch clubs. A carer's clinic was held every month at the practice in conjunction with Devon Social Services to support patients caring for relatives.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual review to check their health and medication needs were being met. For those people with the most complex needs the named GP and nursing team worked with relevant health and care professionals to deliver a multidisciplinary package of care. Research carried out at the practice in conjunction with Exeter University had improved the quality of care for patients with respiratory disease and hypertension.

Families, children and young people

Good

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

Sick children arriving for treatment were seen quickly by the duty GP as a priority, and kept isolated if considered to be infectious.

Systems were in place for identifying and following up children living in disadvantaged circumstances and who were at risk. For example,

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children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations because reminders were sent to parents.

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. The practice signposted young people dealing with grief to a local charity for additional practical, emotional and social support.

A challenging area for the practice was enabling young people to access emergency contraception and sexual health support. The practice had overcome the challenges of being in a close community with infrequent public transport through increased receptionist training and working closely with other neighbouring practices. Young people from the practice could be seen by neighbouring practices through their school.

We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion such as smoking cessation and screening which reflects the needs for this age group. Health & well-being checks to patients aged 40-74 years old who do not have a chronic disease were being carried out by GPs and nurses. Invitations had been sent to this group of patients in for a general check-up and opportunistic checks done when patients attended about another concern.

Carers registered with the practice that also fell in to the working age group, were referred to the practice by a local carers group. They had been offered a comprehensive carers' health and well-being check. A carers clinic was held every month at the practice in conjunction with Devon Social Services to support patients caring for relatives.

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People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people living in vulnerable circumstances.

The practice had a policy on patient dignity requiring staff to treat people from all backgrounds with respect and provide for their needs. Any person arriving at the practice in need of medical attention would be seen at the practice if this was the appropriate place of care, regardless of social, demographic or personal circumstance. Although small in number, the practice was sometimes used by traveller families. The practice kept in touch with the families via mobile contact numbers to ensure any abnormal test results were followed up.

Patients with a learning disability were known to the practice and their health and well being closely monitored. Carers confirmed that the team were attentive and supportive to their relatives with a learning disability. Data showed that 100% patients with a learning disability had received an annual health check. The team worked closely with other agencies and GPs had attended case conferences with social services when patients needed safeguards in place to protect them

People experiencing poor mental health (including people with dementia)

Outstanding

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

The level of health checks and support people experienced exceeded national averages. An example of outstanding practice was how the practice communicated and developed trusting relationships with patients with complex mental health needs. Longer appointments and home visits were available. Staff knew their patients well enough to detect early signs of relapse and worked closely with them and their family to keep them safe. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For example, 90% of patients had experienced a discussion about their lifestyle and about their drinking and smoking habits. Cervical screening had taken place for 100% female patients with complex mental health needs.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice supports patients living in an adult social care home. Advance care planning was in place and 91% patients with dementia had been reviewed face to face in the previous 12 months.

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The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency or were hospitalised, where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

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What people who use the service say

The 2014 national GP survey results for the Mid Devon Medical Practice based on 139 (3% of patients on the practice list) responses were better in most areas compared to the clinical commissioning group (CCG) and national average. In the survey, three areas for improvement were highlighted by patients. These focussed on opening hours, appointment length and experience. The practice had considered these comments and increased the number of staff and roles and responsibilities of some staff were being reviewed to improve patient experience.

During the inspection, we spoke with eight patients. The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experiences with us. We collected 29 comment cards, which contained detailed positive feedback about the Mid Devon Medical Practice.

The overarching theme from patients in their responses in comment cards was that staff had a caring attitude and listened. Staff were described by patients as being kind, compassionate and responsive when they saw them. Patients were confident about the advice given and medical knowledge of their GPs. They told us they were asked about their lifestyle and given support when needed, for example to quit smoking. Access to appointments and the length of time given was described as a high point by patients who told us they never felt rushed. Patients were positive about the continuity of care they received from the team. Some patients were also carers and told us they received excellent support, which helped them care for their relative.

These findings were reflected during our conversations with patients. All of the patients gave positive feedback. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were excellent and closely monitored their health with reminders for vaccinations and screening such as blood tests.

Parents told us the staff treated their children with respect. We were told the staff communicated with children and young people at the right level. Parents said this helped reduce any anxieties their child might have had about visiting the practice.

Patients were happy with the appointment system and said it was easy to make an appointment. Patients said they rang the practice and were offered a same day appointment. Patients felt listened to and said they had no complaints. Information about how to make complaints was clearly displayed and patients told us they were confident that if they did have any concerns they would be acted upon.

The building was highlighted by patients as being accessible for people using mobility aids, safe, clean and tidy.

Patients said it easy to get repeat prescriptions arranged and collected their medicines from the onsite dispensary the same day.

Areas for improvement

Action the service MUST take to improve

- Ensure that repeat prescriptions are signed by a GP before the medicines are given to the patient.
- Review how controlled drugs are handled to ensure that the standard operating procedures are followed.

Action the service SHOULD take to improve

- Extend the audit systems to include infection control arrangements to demonstrate that learning and actions have led to sustained change and provide assurance of risk management.

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- Consider other options, such as a virtual patient participation group (PPG) to engage patients in the on-going development of the service.

Outstanding practice

- The care and treatment of patients at the practice was evidence based. There were several examples of latest developments and equipment being used to treat people, which resulted in early diagnosis and a more responsive approach to treatment. Research carried out by one of the GP partners had led to patients benefitting from increased knowledge, early diagnosis and more accurate monitoring of hypertension. As a result, patients with early signs of potential long term conditions which put them at risk of strokes were detected and commenced treatment sooner.
- The involvement in a pilot scheme and continued use of a centrifuge had increased the lifespan of blood samples so that patients did not have to travel for up to five hours on public transport to the local hospital.
- Staff were innovative in the way they engaged with patients with complex mental health needs. Named staff had developed close relationships with patients at risk so that early identification of behaviour which might lead to self harm was recognised and acted upon to prevent crisis. As a result, the practice was performing better with regard to health screening for vulnerable groups of people.

Mid Devon Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a **CQC Lead Inspector.** The team included a GP specialist advisor, a CQC Pharmacist inspector: a Practice Manager specialist advisor and an Expert by Experience. (a person with experience as a patient or carer, who took part in the inspection by talking to patients and observing the surroundings).

Background to Mid Devon Medical Practice

Mid Devon Medical Practice is a GP practice providing NHS primary care services for approximately 5000 patients. The practice provides a service to people living in Witheridge and surrounding villages in Devon covering approximately 300 square miles. The practice consists of three GP surgeries based at Witheridge, Morchard Bishop and Cheriton Fitzpane. All three surgeries have dispensaries, which we inspected on Monday 27 October 2014.

At Mid Devon Medical Practice there is a higher percentage of patients over 50 years old registered with the practice when compared to national averages. There are few children and young people registered. The practice covers an area that falls into the mid range for social deprivation.

The practice has a total of three GP partners who are supported by three salaried GPs and three qualified nurses, comprising of 4 male and 5 female staff. There is an administrative team consisting of a practice manager and receptionists.

Witheridge Medical Centre opening hours are from 8am – 6pm (closed 1pm -2pm). Patients are able to collect medicines from the dispensary on Monday, Wednesday and Friday 9am – 6pm; Tuesday and Thursday 9 am – 4 pm (closed 1pm -2pm).

Cheriton Fitzpane Surgery opening hours are from Mon 8.30am - 2pm; Tue & Wednesday and Thursdays 8.30am -1 pm and 2pm - 6pm, Friday 8.30am – 2pm. Patients are able to collect medicines from the dispensary at Cheriton Fitzpane Surgery which is open at the same times as above.

Morchard Bishop Surgery opening hours are Monday and Friday 8:30am - 1:00pm; Tuesday and Thursday 8.30am – 6.30pm (closed 1-2pm). Patients are able to collect medicines from the dispensary on Monday, Wednesday and Friday between 10am - 1pm; Tuesday and Thursday 10am – 6pm (closed 1pm-2pm). Emergency Out of Hours cover is delivered by another provider.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

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.

Detailed findings

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included information from NHS England, NEW Devon CCG, Devon Health watch and the local council Health and Scrutiny Board. We looked at the 2014 patient survey and corresponding action plan the practice had in place. We carried out an announced inspection on 27 October 2014. During our visit we spoke with staff (GPs, nurses, healthcare assistants, managers and administrative staff). We spoke with eight patients who used the service. We observed how patients were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 29 comment cards where patients and members of the public shared their views and experiences of the service.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last two years. NHS England told us the practice shared serious event audits (SEAs) and serious incidents requiring investigation (SIRIs) with them, so was considered to have a good reporting culture. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were discussed at practice meeting's with a dedicated meeting occurring every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. For example, at a recent meeting it had been highlighted that there had been some errors in assigning documents to the wrong patient. All staff were reminded to scan the documents before being assigned to the named GP for the patient.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system used to ensure these were managed and monitored. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, we looked at records about a significant event in September 2014 relating to the incorrect dose of a controlled medicine being ordered for a patient. This error was picked up by staff before the medicine was given to the patient. Minutes of two meetings showed this had been discussed the following day and again with the team of staff so that they were aware of the event and changes made to prevent this happening again. A buddy system had been set up so that two staff now signed off and dispensed the medicine to a patient. These checks were in addition to those carried out by the duty GP who had to cross check the scripts with the requisition and order when stocks were being replenished for the dispensary.

National patient safety alerts were disseminated by email to practice staff and were accessible on the practice intranet. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at daily meetings between GPs and the nursing team to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The team had clear oversight of patients who could be at risk of unplanned admissions to hospital, receiving palliative care or had complex care needs. Minutes of six weekly meetings were seen demonstrating that the team worked in close collaboration with other health and social care professionals to manage and review the risks for vulnerable patients. We met three patients with long term conditions. They described positive experiences with the practice, which they felt promoted their safety. They told us the practice was responsive in providing treatment and additional support at times of crisis, which they said had reduced the risk of unplanned admissions to hospital.

Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children who had been trained to

enable them to fulfil this role. This GP said they were in the process of completing level 3 training about safeguarding children. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Three examples were discussed with the safeguarding GP lead and lead nurse, both of which demonstrated that the practice worked collaboratively with the safeguarding board, parents and other health and social care professionals to protect the children involved. GPs had attended child protection meetings and minutes were obtained. Staff explained that patient records flagged concerning information and highlighted potential risks for vulnerable adults and children using a coded system. The safeguarding lead explained that the practice had identified vulnerable adults and worked closely with other health and social care professionals to protect people.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. The practice policy highlighted that only nurses carried out chaperone duties. Chaperone training had been undertaken by all nursing staff. The staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

The practice must improve the way they manage medicines. The practice offered a full range of primary medical services and was able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises. We checked the arrangements for looking after medicines in the main practice at Witheridge and the two branch practices at Morchard Bishop and Cheriton Fitzpane. Each of the practices had a dispensary. All the dispensaries used the same procedures to maintain consistent standards. Dispensary staff told us they usually worked at one practice but would work in any of the practices as the need arose.

Safe systems were in place for the generation of repeat prescriptions. Patients had a number of ways to request their repeat prescriptions. Staff had arranged with some patients for their repeat prescriptions to be generated automatically. Repeat prescriptions had an annual review date after which staff could not generate a repeat prescription unless the GP had reviewed the prescription. Prescription pads were kept secure when not in use. Safeguards were in place to make sure that high risk medicines were identified and regularly monitored.

Systems for the safe dispensing of medicines need improvement. Patients were given their repeat medicines before the prescriptions had been checked and signed by the GP. The prescriptions were kept with the dispensed medicines. Staff said that prescriptions were always signed by the GP on the day they had been given to the patient. This system was not included in the practice's procedure for dispensing of medicines.

Medicines were stored securely at each of the practices and were only accessible to authorised staff. Medicines were stored at the required temperatures. Staff monitored the temperatures of medicines refrigerators to make sure these medicines were safe to use. Each practice had a supply of emergency medicines. These were checked regularly to make sure they were in date and safe to use.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. We checked the arrangements in place at each practice. At one practice the controlled drugs were not stored according to the practice procedure. We brought this to the attention of the dispensary staff and the practice manager. Immediately after the inspection, the practice manager sent us information showing they had taken action to address this issue by ordering a new secure cabinet to store these medicines.

There were arrangements in place for the recording of controlled drugs. There were several slightly different controlled drugs registers in place. This increased the risk

of staff making mistakes as they completed them. We saw examples where records had not been completed correctly. The practice manager arranged for one form of register to be available and staff to have training to make sure records were completed accurately.

Arrangements were in place for the disposal of out of date controlled drugs and of those returned by patients. However, there were a number of out of date controlled drugs in one practice, due to delays in a suitably qualified person being available to go and destroy the stock. A further request was made to the local area medicines team to make sure these out of date medicines would be disposed of safely.

Directions in line with legal requirements and national guidance were in place for nurses administering vaccines. There were up to date copies of these directions, which staff demonstrated they followed. There was a hard wired refrigerator in the treatment room for any items requiring cold-storage and temperatures were monitored to ensure these medicines were stored correctly. Nurses responsible for carrying out this task showed us the stock control system in place and vaccines used for patients were within date. Three patients attended appointments for flu vaccination during the inspection. Patients said that the nurse had first checked whether they had any allergies before giving the vaccination. All of the patients said the nurse had answered their questions and given them information about the vaccine before leaving. This promoted patient health and safety.

Cleanliness & Infection Control

Eight patients we spoke with told us the practice was always clean and tidy and this was borne out by our observations. Twenty nine patients in comment cards fed back that they had no concerns about cleanliness or infection control.

The practice had a lead GP for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. and had received an update in February 2014. Nursing staff said they had carried out two audits of treatment areas in 2014. However, they said there was no written record of the audits available. Practice meeting minutes showed the findings of the audits were discussed with staff and changes made as a result. For example, the practice had upgraded the seats in the waiting room to improve cleaning and reduce the risk of infection for patients.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. Nurses told us they cleaned equipment used to test patients' blood pressure and lung capacity after every patient.

Policies in place covered areas such as personal protective equipment including disposable gloves, aprons and coverings, and these were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury, which linked with occupational support for staff in the event of an injury. Staff told us they had been made aware of the latest guidance about needles and were using safer equipment outlined in this document.

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

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Records showed that the practice had been risk assessed by an external contractor. Action plans had been put in place following the assessment to reduce the risk of infection to staff and patients. For example, seating in the waiting room had been replaced so that it was easier to clean.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly for patient use and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. Calibration of medical equipment was undertaken by an external contractor annually and we saw the inspection report and certification for 2014.

Requires improvement

Are services safe?

Staffing & Recruitment

We looked at four staff records, all of which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only nurses had this additional duty and a DBS had been obtained for all of them.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Two nurses said they were never expected to work outside of their scope of practice. They shared examples of how their professional competencies linked with health promotion clinics being delivered. For example, a nurse had completed level 3 diabetes management training and a recent master class so was able to initiate insulin use and management for patients. The other practice nurse had a specialist interest in care and treatment of patients with respiratory disease and their training records showed they regularly updated their knowledge. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records demonstrating that actual staffing levels and skill mix were in line with planned staffing requirements. One of the GP partners held dual qualifications of being both a GP and pharmacist. This GPs skills were recognised ensuring there was appropriate accountability and leadership of staff responsible for dispensing medicines. Nursing staff had a broad range of responsibilities, including health screening such as taking blood pressures and blood for testing. The practice had recognised that these tasks could be carried out by a phlebotomist or health care assistant, which would free up more nursing time for patients with more complex needs. The GP partners and practice manager said that they had been reviewing the team roles and responsibilities with this in mind.

Monitoring Safety & Responding to Risk

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

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, minutes showed that flu vaccines were ordered early as a result of problems with supplies the previous year.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

- For patients with long term conditions there were emergency processes in place. All of the reception team had been trained to recognise potential emergencies. Patient records highlighted potential risks such as allergies and reminders to ensure annual checks had been done. The practice had a priority triage system in which the duty GP carries out an assessment of the patient. Staff gave us examples of referrals made for patients that had a sudden deterioration in health. Three patients with long term conditions explained they had a care plan in place, which set out potential risks and early interventions to prevent their health from deteriorating. For example, one patient wrote in a comment card that closely monitored and was attending the practice for treatment every month at part of the plan.
- There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. GPs said that they did not hesitate in contacting the consultant at the local paediatric assessment unit if they had concerns about an acutely ill child.

Requires improvement

Are services safe?

- Emergency processes were in place for acute pregnancy complications. Reception staff were confident in describing the actions they would take in this situation, which was to immediately involve the duty GP so that an assessment was carried out.
- Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. For example, named staff monitored a patient closely who was diagnosed with an eating disorder. The staff knew this patient well and were able to describe triggers and behaviours which would indicate that their mental wellbeing was deteriorating. Staff explained that they had recently had to initiate an urgent admission to the eating disorder unit, when the patient's weight had fallen below a safe level and they were beginning to talk about self harming behaviour.
- The practice monitored repeat prescribing for patients receiving medication for mental health needs. For example, some patients attended the practice to be given long acting medication. Staff explained that if patients failed to attend for these appointments they knew this could be a sign that the patient's mental health was deteriorating. They then followed procedure and contacted the community mental health team for assistance to check the patient's mental well being.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and had annual updates on this. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In minutes of a GP & nurses meeting, we saw that medical emergency equipment was discussed. Oxygen equipment been increased so that nebulizer mask was more easily available if needed.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, we saw the plans included being supported by the two other branch practices linked to the practice so that patients would experience continuity of care.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. Records showed that regular fire drills were undertaken. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. For example, a full time GP had reduced their working hours as they had an academic role at Exeter University. The practice identified a number of risk factors linked with this changed such as the impact on continuity of care for patients due to the increased use of locum GPs. The practice chose to replace the GPs hours with a full time GP partner so that the staffing establishment had capacity to cover annual leave without having to use locum staff. The registered manager and senior GP partner explained this had a positive impact having increased the length of time patients were able to spend seeing their GP.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, GPs discussed NICE guidance at their six weekly meetings and had recently discussed the latest NICE guidelines published in September 2014 about current antidepressant treatment for adults and were prescribing accordingly.

The GPs told us they lead in specialist clinical areas such as minor surgery, emergency medicine, diabetes, heart disease and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. GPs and Nurses were very open about asking for and providing colleagues with advice and support. For example, GPs met informally with the Nurses to discuss issues and share best practice guidelines at lunchtimes.

The prescribing lead GP partner showed us data from the local CCG of the practice's performance for prescribing pain relief which was comparable to similar practices. The GPs utilised an IT system for repeat prescribing and knew the practice was consistently within budget for medicines.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers, who were referred and seen within two weeks.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture at the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. We met eight patients with diverse needs who all said GPs referred them to specialists without hesitation when a second opinion was required.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last year. For example, an audit of patients with suspected hypertension had been carried out. This showed that the GPs were following NICE guidelines and correctly ruling out or diagnosing and treating patients with hypertension. There were action points for the GPs and Nurses to focus on patients with a blood pressure reading between 140-149, to rule out and prevent potential missed diagnosis of hypertension. The practice newsletter informed patients about important research being done by a GP at the practice into hypertension, the increased risk of having a stroke and importance of accurate monitoring of blood pressure. This research had been done in conjunction with Exeter University and published in a national journal to promote best practice across all primary medical services. The research highlighted that blood pressure could vary when taken from one arm. To manage potential risks for patients the research made several recommendations including taking blood pressure readings from both arms of a patient. Patients at Mid Devon Medical Practice were benefitting from this knowledge and were having their blood pressure monitored more frequently with equipment that had a higher degree of accuracy. Patients who were at risk of having a stroke had been identified and promptly started on preventative treatment.

Another audit seen showed that patients on medication to prevent blood clots had been reviewed and arrangements for monitoring had improved as a result of this. The practice now used an IT system, which allowed blood results to be analysed quickly so that GPs were consistent in making decisions about alterations to the dose of medication prescribed for patients.

Good

Are services effective?

(for example, treatment is effective)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of analgesics and non steroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Nurses were also subject to clinical audit cycles. For example, nurses explained that cervical smears were audited and they had to be revalidated every 3 years to carry these out. Results of smear tests were always checked by the lead nurse. 'Inadequate' smear test results led to the patient being recalled and additional audits being triggered for the individual nurse who carried out the test. This ensured the cervical screening service was constantly monitored for patients.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 98% of patients with diabetes had an annual medication review, which included screening the patient for known risk factors such as peripheral vascular disease and kidney failure. The practice also met all the minimum standards for QOF regarding asthma, chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF or any other national targets. In some of these targets the practice was better than expected and this included carrying out cervical screening for 100% of patients diagnosed with complex mental illness.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of Nurses and GPs. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. For example, one of the nurses had carried out a wound management audit, which looked at the treatment and healing outcomes for patients with leg ulcers. An audit of patients on the combined contraceptive pill carried out by a GP had identified patients with higher risk factors such as smoking. The information gained was used to target health promotion advice and signpost patients to the smoking cessation programme.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. This showed GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, data showed that GPs at the practice were better than average at reviewing all patients on the palliative care register with other health and social care professionals who might be supporting them in the community.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs, for example one GP partner specialised in cardiac disease and has held a Clinical Academic Fellowship in the Primary Care Research Group of the Peninsula College of Medicine & Dentistry. Five GPs have additional diplomas in sexual and reproductive medicine, and with diplomas in children's health and obstetrics. Another GP held a pharmacist qualification. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

All of the staff interviewed confirmed that annual appraisals were undertaken. These identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in

providing training and funding for relevant courses. For example one of the nurses was in the process of doing a university based foundation course in general practice nursing.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. These duties included immunisation of babies and children, cervical screening and blood taking. Two out of three nurses were working and explained that the administration team had information about their scope of practice which was linked to completed training and assessment of competence. They confirmed that they were never asked to work outside of their professional competence, so worked within safe boundaries when caring for patients. Both nurses were responsible for management of patients with long-term conditions such as asthma, chronic pulmonary disease, diabetes and coronary heart disease. They both had completed appropriate training and held additional qualifications to fulfil these roles. For example, one of the nurses verified they had completed the level 3 course in the management of patients with diabetes, which enabled them to initiate insulin treatment.

Working with colleagues and other services

Educational meetings run by secondary services were attended by GPs at the practice. For example, GPs had attended meetings with a consultant psychiatrist to increase their understanding about diagnosing dementia for patients and support available in the area. This included making timely referrals for patients to the memory clinic at the local hospital so a definitive diagnosis could be made and followed up with support. We saw information about this in the waiting room.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their records. These were used to co-ordinate holistic care for patients receiving palliative care and demonstrated that the team works collaboratively with the local hospice to meet patient needs.

Areas of potential unmet need for young patients regarding mental health support in the local area had been escalated to the CCG by the GPs at the practice. For example, access to inpatient services for young patients in mental health crisis had been raised as a concern and potential focus for future service commissioning.

A challenging area for the practice was enabling young people to access emergency contraception and sexual health support. The practice had overcome the challenges of being in a close community with infrequent public transport through increased receptionist training and working closely with other neighbouring practices. Young people from the practice could be seen by neighbouring practices through their school.

The practice used an electronic patient record system, into which results from investigations such as blood testing, letters from consultants and discharge letters from hospital were scanned in. Specific staff oversaw this process each day and created a task within the system for the patient's GP to review the results. There was a duty system in place for GPs to ensure that patient's results were reviewed every day and action taken where necessary.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient information to be shared in a secure and timely manner. The practice had a list of patients who were vulnerable, at risk due to long term conditions and those receiving palliative care. Electronic systems were also in place for making referrals to secondary care services.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency Department. The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information about this system was published on the practice website for patients and clearly explained the circumstances when information would be shared with other health or social care professionals.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The practice manager explained that they were currently reviewing the IT system due to limitations and exploring other options

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

All of the staff we met were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. GPs and Nurses we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). One of the patients we spoke with was a parent and confirmed that all of the staff communicated well with their children. They verified they themselves were always present with the child during the appointment.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, when interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had been followed in 100% of cases.

Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

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

The practice also offered NHS Health Checks to all its patients aged 40-75 every week. This had been effective in early identification of long term health conditions for example. For example, a new patient had been diagnosed with chronic kidney disease and was immediately sent for further investigations and treatment started.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all the patients were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months. Similar mechanisms of identifying at risk groups were used for patients who had mental health needs and those receiving end of life care. For example, 90% of patients with complex mental health needs had been assessed with regard to lifestyle choices such as alcohol consumption. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake of patients with complex mental health needs was 100% which was better than the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following-up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For example, parents told us that the practice sent out regular reminders so their children were up to date with the immunisations. The practice had carried out a comprehensive risk assessment and set out plans for the 2014 – 15 influenza vaccination campaign. This showed the practice used many different approaches to make the public aware of the vaccination programme. The uptake of at risk groups of patients for flu vaccination was higher than the national averages.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The verbal and written feedback we received from 37 patients in total had common themes about their experiences at the practice. They highly praised all of the staff who work at the practice. Patients talked of staff being professional, friendly, helpful and caring. One patient said staff were second to none and another said staff were excellent and went beyond what was expected of them. Patients told us staff were respectful and polite.

Privacy and dignity were respected. At the reception desk patients observed a respectful distance. We observed interactions between reception staff and patients. These were polite and professional. There was appropriate screening in consultation and treatment rooms. Patients said chaperones had been offered and sheets used to protect dignity during intimate examinations.

Care planning and involvement in decisions about care and treatment

The practice participates in the annual national Quality and Outcomes Framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. Information we reviewed from the QOF monitoring, indicated that 93 % of patients with a documented care plan had been involved in decisions about the content.

Patients told us they felt involved in the decisions about the care and treatment they received and were able to decline treatment. None of the eight patients we spoke with said they had ever felt rushed whilst seeing the GP's or nurses. All eight patients said they felt the GP really took time to listen and acted on their wishes. Staff also worked closely with patient advocates to ensure that decisions made were in the best interest of the person they were treating. For example, a carer told us they and external advocates had met with their son's GP when he needed more invasive treatment. They told us their son was learning disabled and did not have mental capacity to weigh up the potential risks involved in this treatment.

Patients told us they were asked for their consent before any invasive treatment was provided. A parent confirmed they had been asked to give consent before their child was given immunisations.

We did not speak to any patients whose first language was not English. Staff told us there were facilities to access a telephone and face to face translation service should it be required.

The practice and consulting rooms had level access. We saw patients using walking aids were able to move without any restrictions between the waiting and consultation rooms.

Everyone working at the practice was expected to sign a confidentiality agreement as part of their contract of work. The practice had fully investigated a complaint highlighting a potential confidentiality breach. Awareness of confidentiality procedures had been raised with all the staff. Patients we spoke with were not concerned about confidentiality. They were aware their information sometimes needed to be shared by the GP or nurse with other healthcare professionals. The training matrix showed that staff underwent training on information governance (sharing confidential information).

Patient/carer support to cope emotionally with care and treatment

Practice survey information for 2013-14, which we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 97% of respondents to the patient's participant group survey were satisfied with the support services to help them manage their treatment and care. The eight patients we spoke with and 29 comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

The team recognised the risk of social isolation, particularly for older people and those with no family members close by. For example, older people were given information about a local luncheon and walking club enabling them to mix with people from the community.

Notices in the patient waiting room and practice website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and ensured their health was assessed as well as the demands of caring for their relative explored with them.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a

Good

Are services caring?

patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. For example, young people dealing with grief were helped to get in touch with a local charity for additional practical, emotional and social support.

Patients told us the staff did their utmost to give clear explanations and support, which helped to reduce any anxieties they had. For example, a patient said that sometimes they were unable to attend the practice for appointments and the GP would visit or telephone them to discuss any concerns they had.

A monthly carer's clinic was held at the practice in conjunction with Devon social services. This clinic provided support to carers, which included where to get financial, practical and emotional support from.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice responded to their individual health needs well. They said that preferences, such as to see a GPGP of the same sex, were responded to where possible. All of the patients had a named GP. Eight patients we spoke with consistently commented that their GP had an in depth knowledge about theirs and the needs of their family. Patients told us that the practice was reliable, particularly at times of crisis or when in urgent need.

Patients said the prescription system was excellent. Some patients used the on line request service, whilst others called in to collect their medicines from the dispensary. All patients said the process was efficient and often took two days. A system was used to remind patients to come in for health checks before further prescriptions would be issued and patients confirmed this worked well.

Secondary care referral to hospitals or other health providers were made promptly. Patients were able to pick their own routine appointment time through a choose and book system. For urgent referrals to other services GPs completed a template, patient services staff processed it and an appointment was booked.

The practice did not have a patient participation group (PPG) to increase the opportunity for patients to influence the service. The practice manager explained that there had been several attempts to set up a group, but no interest expressed from patients. The GP partners felt that patients might be put off due to the rural location, lack of transport links and low use of online facilities. Plans were in place for the implementation of the 'Friends and Family test', which would be operating from December 2014. This test allows practices to collect feedback daily from patients attending for appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning it's services. For example, the practice was promoting equality in the way it supported patients with a learning disability and/or complex mental health needs. One of the nursing team staff and a GP partner closely monitored the mental well being of a young person who was at risk of self harm. It was clear from the discussions with these staff that they knew the patient well and supported them in a positive way.

The partner GPs were knowledgeable about changes in the local population in terms of ethnicity and diversity of patients registering with the practice. For example, we were told that some patients were part of the traveller community and used the mobile phone network to keep in touch about test results.

Equality and diversity training had been completed by all of the nursing and administrative staff via e-learning. Staff we spoke with confirmed they had completed this training in the last twenty four months and that equality and diversity was regularly discussed at appraisals and team events.

Access to the service

Feedback cards completed by 29 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Eight patients we spoke with told us the appointment system was accessible, available on line, by telephone or bookable in person. We saw reception staff answered the telephone to patients in a friendly way and were accommodating in getting them appointments to see the GPs or nurses.

The practice used a triage system and offered telephone appointments for patients. Patients told us their GP usually telephoned them back after morning practice, which they felt was a good alternative to attending in person for minor issues.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. For example, awareness of maintaining patient confidentiality when speaking with relatives was raised with staff. All of the staff demonstrated they understood the importance of maintaining confidentiality when speaking with patients over the telephone or in person. We saw patients were directed to a privacy booth at reception when they wanted

Good

Are services responsive to people's needs?

(for example, to feedback?)

to speak about a confidential matter. Staff spoke in a low tone and could not be heard. Patients also confirmed this, for example one patient said that confidentiality was always respected.

None of the eight patients we spoke with, or 29 patients who gave written comments had ever made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager.

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

There was clear leadership at the practice. Partner GPs provided robust business and clinical leadership in areas such as safeguarding and specialist care. The practice provided on-going training for future GPs and medical students. The academic position of the senior GP partner meant there was a close link with the university and active input in the development of new knowledge through research to influence other health care professionals. Staff told us they felt they were well supported and enjoyed working at the practice. The changes and challenges staff faced at the practice related to its rural location and on-going financial constraints with the NHS budget. For example, three GP partners told the desire to increase the nursing team to include a healthcare assistant to support the health screening programme had been put on hold for the time being but would be reviewed again. Staff said they received good levels of support through these changes. Staff knew how to raise concerns about whistleblowing and where they would report their concerns. Opportunities to give regular feedback and take part in research and pilots were evident. Care and welfare meetings, reflective practice, access to counselling services and de-briefing after serious incidents were embedded measures supporting staff. The majority of staff told us they felt very well supported.

Staff morale was very high at the practice. Staff said they felt valued and were encouraged to do the best for patients. Clinical and non clinical teams were managed in an open and transparent way at the practice.

Governance Arrangements

All 11 staff we spoke with understood their role and responsibilities and demonstrated appropriate accountability in the way they supported and treated patients in their care. There were clear lines of accountability with regard to making specific decisions, especially decisions about the provision, safety and adequacy of the care provided and these were aligned to risk.

Senior GPs had lead roles, for example one GP was responsible for the protection of patients. Policies and procedures underpinning Adult and Children safeguarding at the practice were kept under review by this GP and referenced national guidance and current local safeguarding processes. Administrative staff held specific responsibilities for example with regard to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were escalated to the GP prescribing lead and were then discussed to raise awareness across the clinical team about potential risks and necessary actions to take.

Practice nurses told us they were supported through the local practice nurse forum and links with the modern matron and other specialist nurses at the hospital. The senior partner GP and practice manager carried out appraisals of the nurses. Training needs were identified and support given to staff to undertake additional training to increase their skill base. For example, the nursing staff held quarterly meetings with the diabetic nurse specialist to review patients with complex and unstable diabetes. This was said to increase their knowledge and skills.

There were management systems in place to monitor the quality of the service provided. Regular reports were provided to the Northern, Eastern and Western Clinical Commissioning Group (CCG). This included performance information, clinical and strategic management. Patient referrals were monitored and there was a quarterly system in place for GPs to check each other's referrals, for example, for appropriateness.

There were clear lines of reporting at the practice, which was clearly monitored through quality and safety processes. For example, one of these processes included senior GP partner oversight of emerging risks with vulnerable patients. The team had a clear overview of the most vulnerable patients, in particular those receiving palliative care. Immediate, medium and longer term actions were in place to mitigate potential risks and promote patient safety, health and welfare.

Leadership, openness and transparency

The practice participates in the annual national Quality and Outcomes Framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. The practice has to achieve targets called indicators in four main sections, called domains. These include clinical care which looks at long term conditions such as asthma and coronary heart disease to make sure the staff are caring for these patients adequately. QOF results for the cycle 2012-13 were achieved by the practice, with some areas better than expected.

Are services well-led?

Good

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

As well as directed audits the practice undertook some internal audits. The practice took part in a pilot to use a centrifuge, which is a piece of equipment that allows blood samples to be kept overnight and still be acceptable to the laboratory for collection each morning. The audit looked at patient blood results, which had led to patients having an unnecessary recall and onward referral to hospital for further investigation. The outcome for patients from this was that audit showed that continued use of the centrifuge helped to improve the quality of the blood samples so that unnecessary hospital appointments could be avoided. This was particularly pertinent for patients at the practice who may have had a five hour round trip to reach the nearest hospital if using infrequent public transport.

GPs met every day to discuss practice issues informally with nursing staff and there were regular formal meetings to promote good communication and team work. These included monthly meetings to review risks and issues arising for patients receiving palliative care, at risk of unplanned admission or with complex care needs, monthly clinical governance and business meetings between GP partners and the practice manager. There were also separate practice nurse meetings for nursing staff to catch up, share information and feedback.

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

The importance of patient feedback was recognised and this tended to be done on an informal basis. The practice manager and senior GP partner explained the challenges of the practice and unsuccessful attempts to get a patient participation group (PPG) off the ground. This was borne out by the comments we had from patients in person and in writing. The practice had instead decided to concentrate on the implementation of the 'Friends and Family test' to capture daily feedback from patients about their experiences.

Management lead through learning & improvement

We saw evidence that the practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, a GP's prescribing had been reviewed. This showed the GP was responsive to patient needs in their prescribing practice and potential risks had been explored with the patient. Another example seen was the revalidation of nurses in cervical screening every 3 years. Nurse held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients were reviewed by the lead nurse. Mentoring and support was provided for nurses to improve their skills and accuracy with such testing.

The practice was signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. An NHS England check of the quality of this service in March 2014 did not identify any concerns.

A random selection of staff files showed they had received an annual appraisal where training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff files contained evidence of professional training and reflection on specific issues. Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by their line manager who had appropriate skills, qualifications and experience to undertake this role.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the signing of repeat prescriptions prior to medicines being supplied to patients. Controlled drugs were not held securely at one location.**