Albany Surgery

Quality Report

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

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Albany Surgery on 7 May 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe well-led, effective, caring and responsive services. It was also good for providing services for the population groups.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from incidents were taken advantage of.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group.
- Patients had a variety of ways to make appointments and found the practice to be flexible in meeting their needs. We were told patients could always get an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients told us the practice was clean and safe.

The practice had a clear vision which had quality and safety as its first priority and high standards were promoted and owned by all practice staff with evidence of team working across all roles.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams to plan and deliver patient care.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They had reviewed the needs of the local population and engaged with the Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available on 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

Summary of findings

available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared and implemented with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear vision and business strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a well-defined leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active in providing the practice with patient feedback. Staff had received inductions, regular performance reviews and attended staff meetings and learning events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for medical conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Staff were responsive to the needs of older patients, and offered home visits and urgent appointments. The practice worked within the '1 care home, 1 practice' model in Newton Abbot. The model allocated a designated GP who cared for the majority of residents in a care home which meant the GP was able to offer regular review visits and develop strong relationships with the residents, managers and staff. There was a carer identification process in place and the practice ensured that this group were informed about various types of support, both financial and practical which was available to them.

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 chronic disease management and patients at risk of hospital admission were identified as a priority. The practice had a consistent approach to patients with chronic disease through close working between GPs and the practice nurse team. Clinic sessions were offered at varying times, to increase flexibility and enable patients to attend. Patients were involved in drawing up and agreeing their care plans. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people 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. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. We saw good examples of joint working with midwifery and health visitor teams and monthly multi-disciplinary meetings were held to discuss children on a protection plan, children in need and families of concern. The practice offered a full range of childhood immunisations in line with national guidance. Children and young

Summary of findings

people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening including chlamydia testing and cervical screening.

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 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 offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

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 and those with a learning disability and offered longer appointments for people within these population groups. Patients with a learning disability were offered annual health checks.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary

organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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 is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice employed a patient services manager that regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The

Summary of findings

practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Patients experiencing poor mental health had also received an annual physical health check.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2014 showed the practice was performing approximately in line with local and national averages. There were 140 responses and a response rate of 57%.

- 73% find it easy to get through to this practice by phone compared with a CCG average of 80% and a national average of 73%.
- 83% find the receptionists at this practice helpful compared with a CCG average of 90% and a national average of 87%.
- 64% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 64% and a national average of 60%.
- 94% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 90% and a national average of 85%.
- 97% say the last appointment they got was convenient compared with a CCG average of 95% and a national average of 92%.
- 84% describe their experience of making an appointment as good compared with a CCG average of 81% and a national average of 73%.
- 58% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 72% and a national average of 65%.
- 53% feel they don't normally have to wait too long to be seen compared with a CCG average of 67% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were all positive about the standard of care received. Patients told us that they could always see a GP and that they were treated well.

Albany Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included, a GP specialist advisor and a practice manager specialist advisor.

Background to Albany Surgery

The Albany Street Surgery provides primary medical services to people living in the town of Newton Abbot and nearby villages.

At the time of our inspection there were approximately 10,000 patients registered at The Albany Street Surgery. There were six GP partners, four female and two male, who held managerial and financial responsibility for running the business. The GPs were supported by two registered nurses, and two healthcare assistant, a phlebotomist (a person trained to take blood) a practice manager, a patient services manager and additional administrative and reception staff. Patients using the practice also had access to community staff including district nurses, health visitors, and midwives.

The Albany Street Surgery is open from 8:30 am until 6pm Monday to Friday. Appointments are available from 8:35am to 5:30pm. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

The practice is a training practice for doctors who are training to become GPs.

The practice had a personal medical service contract that outlined core services to be provided to patients. The practice had not signed up for the provision of enabling patients to consult a health care professional, face to face, by telephone or by other means at times other than during core hours.

Why we carried out this inspection

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

How we carried out this inspection

Before conducting our announced inspection of the Albany Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Health watch, NHS England, and the local Devon Clinical Commissioning Group.

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 May 2015. During our visit we spoke with a range of

Detailed findings

staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients.

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
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

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

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

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during 2014/15 and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result.

National patient safety alerts were disseminated by the practice manager. Non medicine alerts were emailed to all practice staff. Medicines alerts were emailed to the GPs and if action was required this was documented and recorded. All alerts were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with 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 to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had criminal records checks through the Disclosure and Barring Service (DBS).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

Good

Are services safe?

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All nursing staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The last testing date was undertaken in July 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer was carried out in November 2014.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

Good

Are services safe?

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 and rated and mitigating actions recorded to reduce and manage the risk. Examples seen included health and safety, fire, use of electrical appliances, display screen equipment safety, needle stick injury, COSHH (control of substances hazardous to health), manual handling, use of stair lift, and vaccine handling. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice also had a well stocked accessible first aid kit.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills including full evacuation using the evacuation chair on the stairways.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw 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 the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as child health, minor surgery, and family planning. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

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

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had an audit team consisting of the deputy manager and an administrative assistant. The practice showed us a sample of clinical audits that had been undertaken in the last three years and their plan for audits to be undertaken over the next year. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. Examples of audits included one on use of specific antibiotics to ensure they were necessary. Results from this audit showed that these antibiotics were being used appropriately and were needed to provide effective treatment for the patients concerned.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of asthma inhalers which had resulted in more accurate monitoring of inhaler use and the introduction of a strategy for stepping down asthma management as appropriate at routine reviews. The data showed the practice had achieved 100% for the indicators relating to caring for patients with asthma.

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

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

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a manager was undertaking a diploma in management. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of immunisations, ear syringing, would care, travel vaccines, and cervical cytology. Those with extended roles, including seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. The practice had recognised the skills of health care assistants (HCA) at the practice and provided further education and training for them to take on additional roles and health screening. For example one of the HCAs performed well person checks.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was one instance identified within the last year of a referral not being followed up.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, the top 2% of vulnerable patients, patients with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice were also actively involved in the locality '8-8 initiatives', whereby local Newton Abbot GPs had been providing out of hours cover on the weekend for the top 2% most frail patients. The GPs had collaborated so that all of the local GPs involved in this had access to the other practice's computer databases, so were much more informed about the patients.

Information sharing

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. Many hospital referral letters were generated from NICE guideline templates incorporated in the computer system.

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

Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had

Good

Are services effective?

(for example, treatment is effective)

sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback given to us during our inspection showed that patients had different treatment options discussed with them, together with the positive or possible negative effects that treatment can have.

Staff had access to different ways of recording that patients had given consent to treatment. There was evidence of patient consent for procedures including immunisations, injections, and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice. GPs had conducted full reviews of patient's treatment escalation plans and care plans on annual basis or more frequently if appropriate.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80.42% which was comparable to the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for cervical screening. The practice also encouraged patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100% and five year olds from 95% to 99%. Flu vaccination rates for the over 65s were 74.57% and at risk groups 47.49%. These were also comparable to CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

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Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included a national survey performed in 2014/2015. Evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example,

- 95% said the GP was good at listening to them compared to the CCG average of 93% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 91% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.

We also spoke with two patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was situated in a separate room away from the reception area which helped keep patient information private. A system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

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

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

- 94% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 89% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 81%

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

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet

Good

Are services caring?

the family's needs and/or by giving them advice on how to find a support service. Both patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, they were working on a steering group to look at future care provision for the growing elderly population in Newton Abbot.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- Patients told us they were able to speak with or see a GP on the same day, often within hours of requesting the appointment.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or for patients who would benefit from these.
- There were disabled facilities and translation services available.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice employed a patient service manager to provide advocacy services for the more vulnerable patients, including the homeless.

Access to the service

The practice was open between 8.30am and 6pm Monday to Friday. Appointments were from 8.35am to 5:30pm daily. In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them. Patients were able to book appointments on line and there was extensive guidance for patients to enable them to make an appointment with the correct person.

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 and people we spoke to on the day were able to get appointments when they needed them. For example:

- 73% patients said they could get through easily to the practice by phone compared to the CCG average of 80% and national average of 73%.
- 84% patients described their experience of making an appointment as good compared to the CCG average of 81% and national average of 73%.
- 94% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 90% and the National average of 85%

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. For example, we saw posters and leaflets displayed in waiting areas and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint, although none of the patients had made a complaint.

We saw a complaints spread sheet which was used to monitor any trends and used to raise any lessons and identify any action to improve the quality of care. For example, patients had complained about getting through on the telephone in the mornings. The practice had employed additional staff and rearranged the work schedules allowing for more staff to be available during busy times.

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 mission statement which was displayed in the waiting areas and staff knew and understood the values. The practice had a robust 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, for example a GP was responsible for all clinical governance assisted by the deputy practice manager and an administrative assistant. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. Staff were trained in more than one area of work which promoted a sense of team work.
- Practice specific policies had been implemented and were available to all staff on the intranet. Staff explained that any changes, alerts or updates were discussed at their weekly clinical meetings.
- A comprehensive understanding of the performance of the practice was communicated to all staff at the weekly meetings and quarterly staff meetings.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. For example, audits of the use of medicines used for depression.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, a fire risks assessments.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that weekly team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held annually. 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.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, as well as a virtual patients group that carried out patient surveys and submitted proposals for improvements to the practice management team. There were numerous areas were the PPG had initiated changes. Examples being, a new self-check-in on the ground floor, a privacy stand at reception and improved signage around the building which helped make it as clear as possible for everyone, including those with a visual impairment.

The practice had also gathered feedback from staff during staff away days and generally 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. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong 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.