Tavyside Health Centre

Quality Report

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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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Tavyside practice on 26 May 2015. The practice is based at Tavyside Health Centre and provides primary medical services to a diverse population living in the town of Tavistock and surrounding villages in Devon. This includes shared responsibility for monitoring in-patients at Tavistock Hospital.

At the time of our inspection there were 8834 patients registered at the service with a team of six GP partners and one GP retainer (The retainer scheme enables GPs to maintain their skills and development with a view to returning to NHS GP practice in the future). Tavyside is a training practice, with four GP partners qualified as trainers. When we inspected there were three GP registrars on training placements at the practice.

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.

Overall the practice is rated as GOOD.

Specifically, we found the practice to be outstanding for well led. The practice was good for providing effective, caring and responsive services. There were areas of the safe domain which require improvement. It was outstanding for providing services for vulnerable people. The practice was good for providing services to older people, and people with mental health needs including dementia, people with long term conditions, families, babies children and young people and working age people.

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

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available the same day and staff were flexible and found same day gaps for patients needing routine appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Audits were used by the practice to identify where improvements were required. Action plans were put into place, followed through and audits repeated to ensure that improvements had been made.

We saw areas of outstanding practice including:

- The practice was innovative in supporting vulnerable people. For example, a lead GP and health care assistant routinely carried out reviews with patients at their own home. Information was sent to patients in accessible formats that suited their needs, for example in easy read or picture formats. This promoted a trusting rapport with patients and had increased patient involvement in the management their health and well-being and resulted in 100% of patients having been reviewed and followed up
- The practice was innovative involving the association to hold health promotion events every few months. For example, the association had been made aware of a scheme to promote independence for older people. As a result of this, the association with support from the practice had run a 'driving longer, safer course' and another one was planned for June 2015 due to the success of the previous one. Other examples of awareness events held covered living with diabetes, prostate cancer and promoting altruistic kidney donation

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

Importantly the provider must:

Establish and operate effective recruitment procedures to ensure that information regarding pre-employment checks is kept

The provider should:

Record when the performers list has been checked

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.

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 and the practice demonstrated they reviewed resources in line with patient needs. Recruitment practices required improvement to ensure that staff were fit to work at the practice or safe to carry out chaperone duties.

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. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Tavyside Health Centre is a training practice and the quality of training and support provided for trainee GPs and doctors was rated highly by the deanery. 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 taking place. Staff had support to develop their skills to improve performance and provide effective health monitoring for patients at the practice. Staff worked with multidisciplinary teams, which included strong links with other health and social care professionals supporting patients at the end of their lives.

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. The majority of the 23 patients involved in the inspection gave positive feedback. A common theme was that the staff were supportive and patients were always treated with respect and compassion. This was borne out in the way staff engaged with patients with complex communication needs and homeless people in particular.

Summary of findings

Staff we spoke with were aware of the importance of providing patients with privacy. Information was available to help patients understand the care available to them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was reviewed and acted upon.

Are services well-led?

Outstanding

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

It had a clear vision and strategy. There was a strong collaboration and support across all the staff and a common focus on improving quality of care and people's experiences. The practice had strong links with the Peninsular Medical School Deanery, providing placements for medical students and trainee GPs. There was clear proactive approach to seeking out and embedding new ways of providing care and treatment, for example by developing care and treatment pathways overseen by the nursing team. There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. Innovative approaches were used to seek feedback from patients and involve them in health promotion for the local population. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice held a list of older patients with 979 patients registered over the age of 75 and utilised this information to focus on their needs. All of the patients over the age of 75 had a named GP and had been notified accordingly.

The practice proactively managed vulnerable older patients who could be at risk of unplanned admission. Community nursing staff confirmed that this worked well and GPs were accessible to them every day to review on-going needs of patients. The practice had shared responsibility with another practice for providing GP input into managing the care and treatment of inpatients at Tavistock community hospital. This provided continuity of care for older patients following discharge from hospital.

Nationally reported data showed that outcomes for patients were good for 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. There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients nearing the end of their lives.

Patients with complex care needs were well monitored by the practice working in partnership with other agencies. They were responsive to the needs of older people, and offered GP home visits and rapid access appointments for those with enhanced needs.

GPs were proactive in reducing risks associated with poly pharmacy for older people. For example, patients prescribed multiple different medicines had been frequently reviewed and changes made to reduce these.

Information systems enabled the practice to appropriately share important clinical and social information about patients with complex needs. This facilitated continuity of care for those patients.

Pneumococcal vaccination was provided at the practice for older people. In 2014, the practice had run walk in flu clinics as well as the standard week day appointments. Shingles vaccinations were also provided to patients who fit the age criteria. Patients were contacted to offer them the opportunity to make an appointment to have the vaccination, which had increased the uptake of patients being given this.

Summary of findings

The practice held regular carers clinics and works with a community support worker to provide additional help for carers.

The practice worked in collaboration with the Tavistock Area Support Service (TASS), which is a charitable/voluntary organisation. A member of TASS attended the practice on a monthly basis to highlight the services they have available. Leaflets about support services were displayed in the practice waiting room and patients signposted to these as needed.

People with long term conditions

Good

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

The practice held a list of older patients with 1,988 patients with a long term conditions. This included patients with diabetes, cardiovascular disease, asthma, chronic obstructive pulmonary disease, multiple sclerosis and parkinson's disease. The practice utilised this information to focus on their needs.

Nursing staff had lead roles in chronic disease management and had dedicated appointments to review patients with diabetes, asthma and/or chronic respiratory disease. Patients at risk of hospital admission were identified as a priority. All these patients had a named GP and a structured annual review to check that their health and medication 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. The practice held multidisciplinary meetings every month to review the needs of all patients with complex long term conditions.

The winter flu vaccination campaign targeted patients at risk, with long term conditions. For example, data showed that 98.15% diabetic patients had been vaccinated against flu compared with the national average of 93.5%.

The practice recognised that patients with long term conditions could be at greater risk of experiencing depression. GPs were proactively screening patients for signs of depression, providing appropriate support and treatment. For example, the practice hosted weekly meetings run by the expert patients self help group. The practice had identified patients with long term conditions that would benefit from this group and supported by sending a mailshot to these patients. Approximately 300 patients were contacted. This is a regular event and the programmes run over a period of 12 weeks for patients.

Summary of findings

Longer appointments and home visits were available when needed. Home visits for patients newly discharged from hospital were undertaken jointly with the community nursing team to carry out an assessment and arrange additional support where needed.

The practice had links with the external health care professionals to provide advice and guidance as required. GPs and nurses from the practice attended a quarterly virtual Diabetic clinic with hospital specialists, to review patient care and treatment.

Health education around diet and lifestyle was promoted by the practice. The practice took an early intervention approach and helped identify and signpost patients to external support. This included assistance with smoking cessation and contact details for the health worker running this was given to patients. Data showed that the practice was one of the highest performing practices in the area.

Families, children and young people

Good

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

The practice held a list of 2,245 babies, children and young people. This was used to target screening, immunisation schemes and safeguard patients. The register also identified which patients were young carers so that their needs could be monitored and support offered where necessary.

Procedures were in place to ensure that all young children were offered an appointment, immediate if necessary, without the need to be triaged. Parents told us they rarely had to wait for an appointment with their child.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The waiting room had toys for children to play with whilst waiting for their appointments.

Emergency processes were in place for acutely ill children, young people and pregnant women with acute complications. The practice had a duty GP system in place, which increased to two duty GPs after 4pm each day to accommodate children needing to be seen urgently after school.

Summary of findings

The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance. Health visitors and midwives were based in the building so could easily access GPs and vice versa each day. The practice was solely responsible for providing general medical services to a local independent school, which had children and young people as boarders. Appointments were available for students after the school day had ended. Close working links with the school nurses at the independent and public school were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided.

Information about contraception and promotion of health was targeted for young people. The practice used social media websites to target young people registered at the practice and used it to raise awareness about contraception and sexual health services. Young people had access to information and could request chlamydia screening and be seen by a practice nurse specifically trained in these areas. Chlamydia testing kits were in all the toilet facilities and consulting rooms at the practice.

Parents with children attending the practice confirmed that they were always present during consultations. Staff understood Gillick principles with regard to assessing whether a young person was able to understand and therefore consent to treatment. Parents told us that all of the staff engaged well with their children so that they found it a positive experience when attending the practice for appointments.

The practice had rented accommodation to the Tavistock Area Children's Centre so it could be based within the same building. Support was being accessed for parents from children's workers and parenting support groups where relevant.

Midwifery clinics were held at the practice for women to be monitored throughout their pregnancy. GPs worked closely with midwives to monitor and respond to any needs identified.

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 practice held a list of 5,141 working age patients and utilised this information to focus services around their needs.

Summary of findings

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 had an online service to enable working patients to book appointments and repeat prescriptions on-line. The practice website offered information about the full range of health promotion and screening available for this group. The practice performance for supporting patients to lead healthier lifestyles was high. For example, 774 patients were identified as being obese and had offered lifestyle advice, with supporting literature. The practice identified 923 patients who smoked and had two health care assistants who were smoking cessation advisors. In the year up to end of March 2015, 67 patients had given up smoking with support from the staff at the practice. The data showed that Tavyside Health Centre was one of the highest performing surgeries in CCG area.

The practice had extended opening on alternate Saturdays for working patients. Appointments were also available for patients to see a GP, practice nurse or health assistant outside of normal clinic hours by arrangement. Patients could request repeat prescriptions on-line at the local pharmacy or in person at the practice. Repeat prescriptions were being given for up to six months as appropriate. Telephone consultations were available with GPs for working patients.

Overseas travel advice including up-to-date vaccinations and anti-malarial drugs was available from the nursing staff within the practice with additional input from the GP's as required.

Opportunistic health checks were being carried out with patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks including blood tests as appropriate, and reminders via SMS texting to have medication reviews.

People whose circumstances may make them vulnerable

Outstanding ☆

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for 52 people with a learning disability (100%) and provided follow-up monitoring which was tailored to each person's needs. It offered longer appointments for people with a learning disability and their carers for reviews. Home visits by GPs and practice nurse were being carried out routinely each week and jointly with the community nursing team to reduce

stress and improve communication. The practice liaised closely with the learning disability nurse specialist to ensure information was communicated in a person centred way, for example in easy read or picture formats.

Homeless people were treated equally and the practice procedures ensured there were no barriers preventing them from receiving health and social care support. Staff demonstrated genuine care and concern about the two people registered at the practice. Staff knew these patients very well and were working closely with the police and other agencies to promote their well being and safety.

Shared care arrangements were in place for patients with complex mental health needs. The practice worked closely with the community mental health team and regularly reviewed each patient. Every patient had a care plan and risk assessment, which was reviewed.

Health education, screening and immunisation programmes were offered as appropriate. This included alcohol and drug screening. Patients with alcohol addictions were referred to an alcohol service for support and treatment and to the local drug addiction service.

The practice worked closely with the community matron to arrange visits to vulnerable patients to assess and arrange any equipment or other assistance needed by the patient and their carers.

Systems were in place to help safeguard vulnerable adults.

Carer checks were carried out and the practice hosted a carer support worker clinic every month to support patients.

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 held a list of people experiencing poor mental health and was supporting 102 patients. The practice worked closely with a social centre in Tavistock to provide services to support patients experiencing poor mental health and their carers.

Flexible services and appointments were available, which enabled patients experiencing poor mental health to have longer appointments at quieter times of the day, avoiding times when people might find this stressful.

Staff were skilled in recognising and responding to patients experiencing mental health crisis, providing support to access emergency care and treatment. The practice worked collaboratively

with the community mental health team and consultant psychiatrists from the mental health partnership trust. Joint reviews were carried out every month which looked at changing risk, to monitor patient safety and mental well being.

The practice had a list of patients with known mental health needs and worked to engage them in healthy living programmes. Each appointment with a patient was seen as an opportunity to screen patients and signpost them to additional services. In house mental health medication reviews were conducted to ensure patients received appropriate doses. For example, patients taking lithium had regular blood tests to ensure safe prescribing.

Advice and support was sought as appropriate from the psychiatric team with referrals made for psychiatry review or entry into counselling. Patients may be encouraged to refer themselves to the counselling service. Information about depression, including a diagnostic questionnaire was available on the practice website for patients to see and use. Patients found this helpful and made them more aware of when to seek help from their GP.

Patients with suspected dementia were being screened and referred to the memory clinic promptly for diagnostic tests. The practice held a list of 94 patients diagnosed with dementia, which included information about who their carers were. Patients had care plans in place, which supported their on-going changing needs and those of their carers. GPs signposted patients and their carers to the memory café in Tavistock where they could network with other people and take part in activities to reduce the risk of social isolation.

Summary of findings

What people who use the service say

The practice sought feedback from patients in several ways. The GP Patient Survey published on 8 January 2015.There were 244 survey forms distributed for Tavyside Health Centre and 131 forms were returned. This is a response rate of 53.7%

Three surveys, including the 2014 national GP survey showed that results for Tavyside Health Centre was better in all areas compared to the clinical commissioning group (CCG) and national average. Patient satisfaction was much higher than the national average, 95.3%compared with 86% in the 2014 GP survey.

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. Twenty three patients gave feedback at the inspection, in person (19) or in writing (4). All of the patients confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

In written feedback, the overarching theme from patients in their responses was that received compassionate care from all of the staff at the practice. They told us that staff took time to listen and often went beyond what was expected of them. GPs were described as being committed and passionate about what they do. Patients told us they were confident about the advice given and medical knowledge of their GPs. Access to appointments and the length of time given was described as a high point by patients who told us they never felt rushed.

These findings were reflected during our discussion with the patient association members. The members explained that the association and patient participation group (PPG) members became one when two practices merged four years ago. They told us the group had a good working relationship with the GP partners. The group had been enabled to be independent and had developed a statement of aims. These aims included increasing patient involvement, facilitating the improvement of services through fundraising and fostering patient loyalty and support for the practice.

The majority of patients who gave verbal feedback gave high praise for the treatment and support they received at the practice. Patients stated they were very happy and were treated with respect and dignity. They told us that the GPs and practice nurses were excellent and thorough when it came to diagnosis, treatment and on-going monitoring of long term health conditions.

Three parents told us the staff treated their children with respect. We were told the staff were good at communicating with children and young people, which in turn helped reduce any anxieties they might have had about visiting the practice. Young children were seen quickly which meant they didn't have to wait for appointments.

The appointment system was praised by patients, who told us it was easy to make an appointment. Patients were well informed of developments and the practice was innovative in engaging them in health promotion events to raise awareness in the local population.

Patients felt listened to and the majority told us they had no complaints. The majority knew how to make complaints and were confident that if they did have any concerns they would be acted upon. Information about complaints was available in the waiting room although not easy to see. The practice guide for patients also contained this information.

Patients were satisfied with the facilities at the practice. The building was highlighted as being accessible for people using mobility aids, safe, clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients told us they found it easy to get repeat prescriptions and could often pick these up from the chemist based on site, or a pharmacy of their choice the same day or next day.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Establish and operate effective recruitment procedures to ensure that information regarding pre-employment checks is kept

Action the service SHOULD take to improve

- Record when the performers list has been checked.

Outstanding practice

- The practice was innovative in supporting vulnerable people. For example, a lead GP and health care assistant routinely carried out reviews with patients at their own home. Information was sent to patients in accessible formats that suited their needs, for example in easy read or picture formats. This promoted a trusting rapport with patients and had increased patient involvement in the management their health and well-being and resulted in 100% of patients having been reviewed and followed up
- The practice was innovative involving the association to hold health promotion events every few months. For example, the association had been made aware of a scheme to promote independence for older people. As a result of this, the association with support from the practice had run a 'driving longer, safer course' and another one was planned for June 2015 due to the success of the previous one. Other examples of awareness events held covered living with diabetes, prostate cancer and promoting altruistic kidney donation

Tavyside Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and another specialist advisor who was a practice manager.

Background to Tavyside Health Centre

The GP partnership run the practice from Tavyside Health Centre and provide primary medical services to people living in the town of Tavistock and the surrounding villages, where the level of social deprivation is low.

At the time of our inspection there were 8834 patients registered at the practice. There is a higher percentage of patients over 55 years when compared to national statistics.

The practice is contracted to provide General Medical Services (GMS). Tavyside Health Centre provides some enhanced services which are above what is normally required covering the childhood vaccination and immunisation scheme, extended hours access, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations as well as monitoring the health needs of people with learning disabilities.

There are six GP partners at Tavyside Health Centre, two male and four female, who hold managerial and financial responsibility for running the business. There is also a female GP retainer. The GP retainer scheme enables GPs to maintain their skills and development with a view to returning to NHS GP practice in the future. The GPs are supported by three female registered nurses, two female healthcare assistants, a practice pharmacist, a female phlebotomist, a practice manager, additional administrative and reception staff. Tavyside Health Centre is a training practice, with three GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students. There were three GP registrars on placement when we inspected the practice.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

Tavyside Health Centre is open from 8 am – 6.30 pm Monday to Friday. Extended opening hours are held every alternate Saturday from 8.30 am – 12.30 pm providing appointments for working patients. The practice also provides appointments before and after clinics by agreement for working patients. During evenings and from Saturday afternoon onwards for the rest of the weekend, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Northern, Eastern and Western clinical commissioning group.

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.

Detailed findings

How we carried out this inspection

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 26 May 2015.

During our visit we spoke with five GPs, the practice manager, one registered nurse, one healthcare assistant, a phlebotomist, administrative and reception staff. We also spoke with 19 patients who used the practice and met two representatives of the patient participation group. We observed how patients were being cared for and reviewed four comment cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

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. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Staff were readily able to locate this information and describe learning and changes made.

Learning and improvement from safety incidents

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 the last three years and we reviewed these. Significant events were discussed every morning at the GPs meeting and the formal review process was a standing item on the practice meeting agenda every month. Minutes recorded actions from past significant events and complaints. Learning from significant was shared verbally with relevant staff and changes made.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example the practice had identified a potential risk of missing recalls and reviews of patients taking antibiotics and anti hypertensive medicines due to the way they were recorded on the patient record system. The practice had changed the way it recorded these medicines so that they were listed under the repeat prescription list to reduce the risk and this had improved the practice performance on recalling patients for reviews.

National patient safety alerts were disseminated by email to practice staff. We were shown examples of these held on the practice intranet, which was also accessible to staff.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. However, the policy for safeguarding children referred to 2006 national documents and had not been updated to include guidance from the document 'Working Together 2013 and Intercollegiate Guidelines 2014' and the Royal College of GPs Safeguarding Toolkit 2014. Discussions with staff demonstrated that they were following these principles in practice.

Training records showed that all staff had received relevant role specific training on safeguarding. GPs, nurses and administrative staff were able to describe 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 accessible but not highlighted within the policies and procedures.

The practice had appointed specific GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example both GP partners had completed training at level 3 for safeguarding vulnerable children. Both had completed awareness and alerter training for safeguarding adults.

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 and linked with other siblings and family members registered at the practice. GPs were using the required codes appropriately on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. For example, a monthly audit of all children and young people who did not attend appointments was done to look for any

concerning patterns. If any were identified, minutes showed these were discussed at a monthly meeting with the health visitor and agreement made about how this would be followed up.

There was a chaperone policy, which was visible on the waiting room noticeboard. However, this was less visible in consulting rooms and not in an alternative format for patients with learning disabilities. 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 of the staff we spoke with understood the principles and verified that they offered patients the choice of having a chaperone. Nursing staff confirmed that they were often asked to chaperone for patients. All nursing staff, including the health care assistants and phlebotomist had been trained to be a chaperone. Reception staff did not act as chaperones.

Medicines management

Medicines were stored securely in the treatment rooms and medicine refrigerators 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. Nursing staff were responsible for monitoring these and knew the safe temperature range for storing medicines. Records for the previous month demonstrated that all three refrigerators were operating within the safe range described by staff.

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

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

Records of practice meetings demonstrated that actions had been taken in response to reviews of prescribing data. We reviewed data which showed that prescribing patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were average when compared with local and national data. The staff team included a pharmacist who worked closely with the clinical team, providing advice and guidance about safe and cost effective prescribing.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines was seen. These included annual flu vaccination, including shingles vaccination. For example, we saw a patient specific direction was being prepared so that the healthcare assistant was authorised to give a patient their regular vitamin injection.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, the practice had purchased specialised equipment and trained a healthcare assistant and phlebotomist to take blood samples to monitor the effects of anti clotting medication. Normally this was done at the hospital and results available to the following day. Instead, patients at Tavyside Health Centre received an instant result and were then able to make the necessary changes to the dose of their medicine. Another benefit for patients was the access they had to immediate advice and support if this was needed. An external quality assurance scheme was used to ensure that the results were within range, safe and accurate to then prescribe the correct does of medicine for each patient. Records showed that audits comparing the practice performance and testing against other practices had been done every three months.

GPs had access to a well stocked grab bag to take out on home visits. The content of this bag was checked every month by a designated member of staff. We saw that all of the contents were in date.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was tightly restricted and the keys held securely.

Requires improvement

Are services safe?

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

The premises was spotlessly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept by the external contractor used. The practice held copies of cleaning audits carried out the external cleaning company and was monitoring the quality of the service provided.

In four comment cards, all of the patients remarked that they were satisfied with the standard of cleanliness at the practice. All 19 patients we spoke with were also satisfied with the cleanliness and infection control at the practice.

The practice had a lead nurse 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. New staff had received induction training about infection control specific to their role. The lead nurse had carried out audits for each of the last three years and improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and the actions implemented. For example, the practice identified that bio hazardous waste procedures had changed with regard to the safe disposal of sharps containing or used to give certain medicines, including live vaccines and immune suppressants. Appropriate containers had been purchased and were being used in all treatment rooms.

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. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff described how they would use these to comply with the practice's infection control policy. The practice had a needle stick injury policy in place and staff knew the procedure to follow in the event of an injury. We reviewed a significant event about a needle stick injury and saw that procedures had been followed. We saw the practice used needles with an integral safety sheath, which was in line with current practice.

Equipment for examination or used to deliver medical gases to patients was single use, was checked monthly and in date.

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.

Other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessments were in place. Staff showed us records demonstrating that the practice was following suitable procedures for managing COSHH requirements. Records also showed the practice was following suitable procedures to reduce the risk of legionella. This is a bacterium that can grow in contaminated water and can potentially be fatal. The practice was carrying out regular checks in line with national guidance to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records demonstrated this was happening in July each year. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and certain types of equipment were calibrated for accuracy for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Information provided by the practice showed that staff retention at Tavyside Health Centre was high. All of the staff told us they enjoyed working at the practice and new staff had been recruited.

Recruitment procedures required improvement. We looked at four files of staff in different roles at the practice, including locum staff. The practice had carried out a risk assessment to determine whether to obtain a criminal record check using the Disclosure and Barring Service (DBS). This needed to be documented as a policy to support the decisions about what level of checks should be undertaken for each role at the practice. A member of staff

who had direct contact with patients verified that prior to working under temporary arrangements the practice had required them to have a DBS check completed before being able to work with patients and held a copy on file.

Two of the four files we looked at were for GPs and we found there was insufficient information in these. A DBS certificate had been obtained and copy held on file for one GP. Staff confirmed that the performers list held by NHS England had been checked for the other GP but there was no written record of this. There was no record of references having been obtained from previous employer, information about immunisation status, photo identification or indemnity insurance information to show this had been checked prior to employment.

Other records seen demonstrated that professional registration checks for the rest of the team were being carried out. This included annual checks of the Nursing and Midwifery Council register and revalidation dates for GPs were known and being monitored with the General Medical Council.

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 duty rota system in place to respond to urgent patient needs and emergencies, for example for GPs which had been reviewed and increased so that there were two GPs on duty each day after 4pm. There was also an arrangement in place for all members of staff to cover each other's annual leave and periods of sickness. Locum staff were used where needed. Staff told us there were enough staff to maintain the smooth running of the practice and 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

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. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Records seen showed that appropriate checks were carried out, for example fire safety equipment had been tested in the last 12 months. Staff training records demonstrated that all staff had completed an induction and fire training, including a drill. Outside of the building we saw a raised metal grill covering a drain, which presented a trip hazard and reported this to the practice manager. This was removed immediately.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. For example, emergency appointments/telephone consultations were always available each day and patients referred onto specialists such as midwifery services for acute pregnancy emergencies. All young children were offered an appointment, immediate if necessary, without the need to be triaged. Rescue medications and emergency equipment was easily accessible and the location known by clinical staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records demonstrated 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).

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, suspected meningitis, hypoglycaemia, severe asthma, overdose, nausea and vomiting and epileptic fit. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of 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. Staff explained that the practice worked collaboratively with three other practices in the area. They told us they would liaise with these practices in the event of an emergency that meant Tavyside could not operate.

Requires improvement

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Fire safety equipment used in emergencies was regularly maintained. The last fire drill had taken place in February 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff were able to give clear rationale for their approaches to treatment. They were familiar with current practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Weekly meetings were held at which the latest guidelines and research was discussed. The practice ran dedicated chronic disease review clinics and had produced several care pathways for the management of patients with long term conditions to support the nursing team in delivering this. For example, we looked at the care pathway for hypertension, this followed NICE guidelines and set out clear parameters for monitoring and treating patients. There was clear guidance about when to escalate concerns to a GP.

The GPs told us they lead in specialist clinical areas such as hospital care, family planning, gynaecology, travel medicine, end of life care, diabetes, heart disease and asthma. Practice nurses had additional qualifications which allowed the practice to focus on specific conditions. For example, all of the practice nurses held a diploma in asthma and chronic respiratory disease were responsible for managing the care of patients with these long term conditions. Data for the local CCG showed that the practice performance for monitoring patients with long term conditions for the year 2014-15 was comparable or better than other practices in the area. For example, 104 patients with chronic obstructive pulmonary disease had been reviewed (100%). Staff told us they were targeting patients with diabetes to ensure that reviews were taking place.

Data from the local CCG of the practice's performance for antibiotic prescribing demonstrated that this was comparable to similar practices with 29% versus the national rate of 28%. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients every week and had on site meetings with other health and social care professionals supporting them.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data showed that the practice was performing well in preventing unplanned admissions for vulnerable patients with Tavyside at 12.22% compared with national average of 13.6%. Data seen also showed that 100% patients with suspected cancers were referred and seen within two weeks. Designated staff dealt with results from investigations and demonstrated that these were seen on the same day by the GP who referred the patient for the investigation or duty doctor.

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. Staff showed us information which was in easy read and picture formats, which they used to enable patients with learning disabilities to be fully involved in making decisions about their care and treatment. Patients in written and verbal feedback gave us examples of this. For example, patients told us they were treated as individuals and their views respected.

Management, monitoring and improving outcomes for people

The practice met with the commissioners to discuss the implications of the Joint Strategic needs assessment for their population. The practice provided information for the commissioners showing the performance with regard to delivering health promotion. For example, 745 health checks were offered to patients over the age of 40 years for the year 2014 to 2015. Of these, 323 patients decided to have screening which amounted to 43.3% of patients eligible over a 5 year period. During these checks a patient was found to have an irregular heart rhythm, an electrocardiogram was done the same day and after seeing a GP the patient was referred to the hospital cardiology service for a review.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling reviews, and managing child protection alerts and medicines management. The information was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us a copy of the last teaching practice report by the Peninsula Medical Deanery, which demonstrated that GPs used an evidence based approach

Good

Are services effective?

(for example, treatment is effective)

and utilise every opportunity to review and improve their practice. GPs showed us six clinical audits that had been undertaken in the last three years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The practice carried out an audit in December 2014 of patients who were receiving, or had ever received adrenaline pens of varying strength to be used in the event of an emergency. The purpose was to ensure that current prescribing guidelines were being followe and ensured appropriate dosage for their body weight. Eighty three patients were identified and resulted in five areas of action, including changing how this medicine was coded on patient records to provide a safety net and ensure patients were reviewed. Some patients received appointments so that their weight was recorded and dosage altered accordingly. The findings were discussed at a clinical meeting in January 2015. 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. For example, a review of 96 patients diagnosed with dementia was carried out to determine whether current guidelines were being followed for their care and treatment. The review identified two patients had been prescribed antipsychotic medication, which was not related for behavioural and/or psychological symptoms associated with dementia. The antipsychotic medication had been initiated by a consultant psychiatrist to treat psychotic symptoms arising as a result of long term mental health problems. The audit concluded that both patients were being reviewed regularly by the consultant and local mental health team. Both had subsequently been diagnosed with dementia. A second audit was scheduled to take place.

There was a protocol for repeat prescribing which was in line with current national guidance. Repeat prescription requests were reviewed daily and signed off by a GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being followed. The IT system had recently been updated so that relevant medicines alerts were flagged up when the GP was prescribing medicines. This enabled the GPs to prescribe according to current guidelines with the most cost effective medicines.

The practice worked to the gold standards framework for end of life care. The nearest hospice to the practice was in Plymouth, so the team of GPs worked closely with the palliative care team to support patients to be at home and receive services there. A palliative care register was held and reviewed regularly. This included monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term medical conditions were offered a minimum of yearly health reviews. Nurses told us that the frequency of these reviews were agreed with patients and dependent upon their health needs. Prior to the inspection, we looked at data for 2013-2014 which showed that the practice was performing slightly below the national averages for monitoring patients with diabetes. We looked closely at the performance for 2014-2015 and saw that this had improved on the previous year with 80.8% of patients having been reviewed, which was comparable with the CCG average. The recall system was seen in process and demonstrated that patients were being invited in for appointments on a rolling schedule each month. Administrative staff explained that each patient received two further letters if they didn't arrange an appointment for an annual review. We looked at the letters and staff told us that if a patient failed to arrange a review the practice had an escalation policy in which a GP reviewed the situation and contacted the patient direct themselves.

The practice had systems in place to monitor and improve outcomes for vulnerable patients. For example, a register of patients with learning disability was held. Information for the previous 12 months submitted to the showed that 100% patients had a physical health check. A lead GP and senior health care assistant had specific responsibilities for managing the care and treatment of people with learning disabilities. The practice went beyond what was expected completing every patient review at the patient's own home with them. Staff told us that this had increased levels of engagement with patients, which led to more thorough health screening for people. The GP and healthcare assistant had both completed training in total communication and were working closely with the community teams supporting people with learning

disabilities. We looked at accessible information in picture and easy read formats that was sent out when a review appointment was arranged with the patient. Other self check information was also used with patients at these appointments, for example, which provided advice about how women should check their breasts or testes for men.

An annual flu vaccination programme had finished and the practice was starting to plan for the following winter when we inspected. Older patients, those with a long term medical condition, pregnant women, babies and young children had all received vaccinations. For patients within the relevant age range a vaccination against shingles was also available and information about this highlighted in the practice newsletter and website. The practice held additional clinics for vaccination as well as when patients attended for other appointments so they did not have to make unnecessary trips to the practice. Patients were contacted via text, phone or email. Data showed that 98.15% diabetic patients had been vaccinated against flu compared with the national average of 93.5%.

Data showed 97.9% of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%.

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 89.73% which was slightly higher than the national average of 82%.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Tavyside is a training practice providing placements for GPs and trainee doctors. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as teaching/training, child care, learning disabilities and complex mental health care. Four GP partners were qualified trainers. Each GP also had specific interests in developing their skills and disseminating this to the team. All GPs were up to date with their yearly continuing professional development requirements and all had 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 the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

All staff undertook annual appraisals with the practice manager and a GP, which included identification of individual learning needs. Five staff confirmed that in preparation for their appraisal they had been asked to identify their training needs and it was discussed with them at the meeting. However, we looked an example of appraisal record and found that this did not include a training section or assessment of training needs. Mandatory training was provided on-line and some staff showed us their training records and paper portfolios with certificates of completed courses. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, administrative staff responsible for summarising medical notes had received training for this.

The nursing staff received their clinical appraisal from a GP at the practice. A nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. The nurses had received extensive training for their roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines and undertaking cervical smears. Healthcare assistants held extended roles, which included delivering health screening for patients over 40 years, carrying out blood checks of patients on anti clotting medicines, giving vaccinations and other medicines via injection and had received training for this.

Working with colleagues and other services

GPs worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. There were policies in place outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. All of the GPs were responsible for seeing these documents and results and for taking action required. Staff understood their roles and felt the system in

Good

Are services effective?

(for example, treatment is effective)

place worked well and our observations supported this. Results and discharge summaries were followed up appropriately and in a timely way. For example, we looked at the electronic inbox and saw that all patient results and summaries were being dealt with as soon as the information was inputted and tasks set within the system for GPs to review. The practice had increased the number of GPs on duty from one to two after 4pm to deal with these and any patients presenting on the day who needed to be seen urgently.

The practice worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children every month. Every month there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team. The practice had a list of vulnerable adults and worked closely with community professionals. For example, community nursing staff based at the practice told us that there was an open door policy at the practice, whereby GPs and nurses were able to communicate and respond quickly when a patient's needs changed. They told us that GPs made themselves available to the team to provide guidance and to support to them in their role as community health workers.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Special notes were shared with the 111 and Out of Hours services for patients with complex needs who needed continuity of care and treatment overnight.

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, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in promoting patient rights. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. For example, GPs shared an example of a patient receiving end of life care who also had dementia and confused about medicines that had been prescribed by the hospital. The GP demonstrated they followed best interest principles and had also raised this as a significant event which identified learning points for the hospital.

All clinical staff demonstrated a clear understanding of Gillick competencies. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The practice was the sole provider of general medical services for children and young people boarding at a local independent school. Close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided. Three parents with children attending the practice confirmed that they were always present during consultations. They told us that all of the staff were good at engaging their child and treating them as individuals.

Procedures were in place for documentation of consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes. However, we found that the form used did not prompt GPs to record that relevant risks, benefits and complications of the procedure had been discussed with the patient. We highlighted this during the feedback and within 48 hours the practice had updated the consent form in line with current national guidance. Nursing staff recorded patient consent for procedures such as wound dressing, blood taking or cervical screening and examples were seen.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. This was young person friendly and in easy read formats. The practice website contained information and advice

Good

Are services effective?

(for example, treatment is effective)

about other services which could support them. The practice offered new patients a health check with a nurse or with a GP if a patient was on specific medicines when they joined the practice.

There was information on how patients could access external services for sexual health advice. The practice had also made chlamydia screening more accessible by creating chlamydia testing packs, which were placed in doctor's rooms and in the toilets in the waiting areas. These were marked for female and male patients and had full instructions about how to use them.

The practice had identified that 774 patients were obese and had offered lifestyle advice, with supporting literature. Nine patients had requested more support and in addition to the lifestyle advice and information had been prescribed medication to support them lose weight and were being closely monitored. Staff shared an example with us about a patient who was overweight and had a long term condition. With support the patient had changed their lifestyle and diet, lost weight and their health was improved as a result.

The practice identified 923 patients who smoked and had two health care assistants who were smoking cessation advisors. Training records showed they had received specific training for this role. Literature about smoking cessation was in both waiting rooms at the practice. In the year up to end of March 2015, 67 patients had given up smoking with support from the staff at the practice. The data showed that Tavyside Health Centre was one of the highest performing surgeries in CCG area; 6,991 out of 7,444 patients had a smoking status recorded on their notes demonstrating this had been discussed with them.

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Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

GPs told us that they supported patients living in care homes in the area. GPs said they aimed to promote patient dignity and respect in the way they approached requests for a home visit or repeat prescriptions. They told us they did so by overriding the normal triage system in place at the practice and assessed patients at their home.

Patients completed CQC comment cards to provide us with feedback on the practice. We received four completed cards and all were positive about the care and treatment experienced. The majority of patients (19) we spoke with said they felt the practice offered exceptional services and staff were caring, helpful and professional. They said staff treated them with dignity and respect. Patients were complimentary about reception staff and told us that every effort was made to give them a same day appointment even for routine issues. Our observations of reception staff responding in person with patients or over the telephone also confirmed this.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations and we did not overhear any conversations taking place in these rooms.

Staff were discreet when discussing patients' treatments in order that confidential information was kept private. There were additional areas available should patients want to speak confidentially away from the reception area. We sat in the waiting room and observed patient experiences as they arrived for appointments. Reception staff were friendly and knowledgeable about patients and treated them with respect.

Staff spoke passionately about promoting equality and showed genuine care and concern for their patients. For example, the practice staff had involved the police in helping to search for one of the homeless people registered with the practice as they hadn't attended and staff knew this was not their normal pattern of behaviour. Staff knew all the potential locations where this person might be and had alerted the police to look in those places for them.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were able to explain how they diffused situations to avoid further escalation of a patient's frustration or anger.

Care planning and involvement in decisions about care and treatment

Data showed that the practice was performing better with regard to maintaining a palliative care register for patients. GPs told us that treatment escalation plans were routinely discussed with patients on the register and their wishes about end of life care needs recorded. Minutes of multidisciplinary meeting demonstrated these were being followed for patients.

Patient survey information demonstrated that the practice achieved a better than expected level of patient satisfaction and involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 77.9% of practice respondents said the GP involved them in care decisions which was comparable with national performance on this. Patient feedback in the same survey showed that 77% felt that the GP was good at explaining treatment and results, which again was comparable with national statistics.

Data showed that 91.2% patients at the practice compared with 87.2% nationally felt that the last GP they saw or spoke to was good at listening to them. The majority of the patients we spoke with (19) told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being good at listening to their needs and acting on their wishes. Patients said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the four comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. Notices in the reception areas and information on the practice website explained the translation services available in a number of languages. However, this was rarely used as patients often chose to bring an English speaking relative with them instead. Practice staff told us they recorded this information in the patient record and the most common language other than English was Polish.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

GP patient survey data showed 95.3% patients described the overall experience of their GP surgery as fairly good or very good, which was much higher than the national average of 87.5%. The four comment cards we received were consistent in describing positive experiences about the care and treatment they had received. Patients highlighted that staff responded compassionately when they needed help and described as going beyond what was expected of them. The practice ran a monthly carers clinic in conjunction a community support worker, to provide practical and emotional support for patients who were carers. Members of the Patient Association and Patient Participation Group (PPG) told us that the practice also had good links with the voluntary sector, including a local drop in centre where patients could get additional support and advice.

The practice was proactive in promoting initiatives aimed to support patients cope with their care and treatment. For example, the practice supported the local expert patients self help group by disseminating information and hosting meetings in the conference room at the practice every week.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Written information was also displayed in the waiting room explaining the various avenues of support available to carers.

Staff told us that if families had suffered a bereavement, they were contacted by a GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The patients we spoke with told us that the staff were caring and compassionate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice held registers for each group including one for vulnerable patients so that the support, care and treatment was patient centred.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Operational meetings were held at the practice every month.

Twenty three patients commented that the prescription system was good. The practice had an online prescription request service, which patients told us worked well. The practice rented premises to a private pharmacy so patients could choose whether to have their prescriptions sent through to this chemist or another one of their choice. The practice had arrangements in place for more vulnerable patients, which included a delivery service of the medicines direct to the patient. All patients said the process was efficient and took a couple of days.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, GPs had responded to changing demands and had implemented more flexibility into the appointment system by opening alternate Saturday mornings from 8 am -12.30 pm.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services.

The practice staff were able to access equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed or were completing the equality and diversity training. All of the staff told us that equality and diversity was regularly discussed at staff appraisals and team events. We saw evidence of these principles being followed, for example in the way reasonable adjustments were made for people with learning disabilities and homeless people.

The practice was situated in a purpose built premises, which was accessible for patients in wheelchairs with ramp access into it. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had an audio loop in the waiting room for those with hearing aids.

The practice had systems in place to support patients whose circumstances may make them vulnerable. For example, the practice had a register of patients who may be living in vulnerable circumstances, with specific information in individual records about potential risks and support that was needed. GPs told us there were no barriers for homeless patients and workarounds were in place to record contact information. Two homeless people were registered as patients and there was an arrangement for all health related correspondence to be sent to the practice for them to collect. Staff told us they tried to fit patients in for appointments if they presented on the day, making appointments accessible. Twenty three patients in person and in writing confirmed that this was also their experience of the appointment system.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Patients were able to book appointments in advance via the practice website.

New patients were given an information pack and introductory letter. This explained that patients registered at the practice did not have a named GP and could choose to see any GP they wished to. The letter did, however warn that if a patient wished to continuously see the same GP they might have to wait longer to see them.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information

Good

Are services responsive to people's needs?

(for example, to feedback?)

on the out-of-hours service was provided to patients. The practice had extended opening hours to alternate Saturday mornings between 8am – 12.30 pm. Patients told us that GPs were very flexible, for example a patient told us their GP offered to see them early before morning appointments started as they had work commitments to get to. In April 2015, seven patients had requested appointments outside of normal clinic sessions which had been arranged with them to suit the person.

Flexible arrangements were in place for working age patients, which extended the opportunities for health screening to take place at one appointment. Repeat prescribing requests could be made by patients in some circumstances for up to six months as appropriate. During the winter months, the practice held walk in flu vaccination clinics on Saturdays between 8 am to 12 midday.

Feedback cards completed by four patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Nineteen patients confirmed that the appointment system was accessible, by telephone, online or bookable in person. Routine appointments were usually for 10 minutes, however one of the GP partners chose to provide 15 minute appointments as routine. Patients confirmed urgent appointments were available on the same day. 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. A duty GP was available every day, with a second duty GP available after 4pm every day. Patients told us their GP usually telephoned them quickly and found this a good alternative to attending in person for minor issues. The practice had a system for prioritising children so that they were seen by the duty GP and were not kept waiting for their appointment.

Longer appointments were also available for patients who needed them and those with long-term conditions. For example, patients with learning disabilities and/or mental health needs were offered appointments at quieter times of the day and for longer periods for up to an hour if necessary. Counselling services were available on site provided by the local mental health partnership trust. Information was displayed in waiting areas for patients and highlighted they could self refer to the depression and anxiety counselling service if they wished to.

The practice provided 24 hour electro cardiogram and doplar services on site so patients were able to avoid having to travel to the main hospital in Plymouth some distance away.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice. We looked at an audit covering 10 complaints received from patients between April 2014 and March 2015, all of which had received a prompt acknowledgement and outcome in writing.

The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. Complaints had been analysed and the audit for 2015 showed a comparison with the previous year audit. From this the practice showed that complaint levels had fallen and on the previous year as the practice was listening to feedback from patients and making changes to the service. We saw the practice had held resolution meetings with patients.

The majority of the patients we spoke with and four patients who gave written comments told us they had never made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager.

Are services well-led?

Outstanding ☆

(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. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. We spoke with 16 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. The majority of the 23 patients we received comments from in person or in writing described the practice as "excellent" and the staff "very caring".

The practice provided on-going training for future GPs and medical students. This included trainee GPs in the Royal Navy. A GP partner was an associate dean with the Peninsular Medical Deanery, which meant there was a close link with the university and active input in the training of medical staff and 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 practice was in the process of recruiting a new salaried GP and had attracted a lot of interest for this position, which was very positive when compared with the nationally recognised challenges of recruiting new GPs.

Staff morale was high and there was a low turnover of staff. As a training practice, Tavyside had attracted interest from trainee GPs in becoming salaried staff. Staff said they felt valued and were encouraged to be innovative to deliver safe and effective care and treatment for patients. For example, the practice had agreed care and treatment pathways to facilitate this and all clinics for patients with long term conditions were nurse led. The practice team was managed in an open and transparent way.

Governance arrangements

The practice had a named GP as the clinical governance lead who had oversight of outcomes relating to patient care and treatment. Statistical data showed that the practice was performing above national average in several areas, particularly with regard to monitoring vulnerable patients and those with long term conditions. For example, 100% patients with learning disabilities had at least an annual health check and followed up according to their specific needs. Child immunisation rates for children at 12 and 24 months of age were high and ranged from 90.9% for meningitis C to 100% for all other vaccinations.

There were a number of policies and procedures in place to govern activity. All of these were available to staff on the desktop on any computer within the practice. The practice manager verified that they used the NHS information governance tool kit. The tool kit was developed by the Department of Health to encourage services to self assess so that they could be assured that practices, for example, have clear management structures and responsibilities set out, manage and store information in a secure, confidential way that meets and data protection. We looked at some of these policies and procedures, which included those covering safeguarding, infection control, recruitment all of which had been regularly updated in light of changing guidance and legislation. Minor changes were needed to some of these, including the consent procedure which we highlighted when we gave feedback at the end of the inspection.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and two GP partners were the leads for safeguarding children and adults. The practice team included a community pharmacist who oversaw with the lead GP all prescribing practices to ensure staff were following current guidance and appropriately monitoring patients. We spoke with 16 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, knew there was a whistleblowing procedure and who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. In the year 2013-2014 the data showed that there were some areas that the practice was performing slightly under the national average for example regarding monitoring patients with diabetes. Staff told us that they had changed the recall system and now had a lead nurse for each QOF. We looked at performance for 2014-15, which showed improvement. The QOF data for this practice showed it was performing in line and in some instances better than expected with national standards. We saw that QOF data was regularly discussed

Are services well-led?

Outstanding ☆

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

at monthly team meetings and action plans were produced to maintain or improve outcomes. All of the staff we spoke with knew how the practice was performing in these areas, what the priorities were and were working on these.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. Risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, cleaning services were carried out by an external contractor and the practice had copies of the audits completed each month. We discussed the findings from these audits and saw that where action was necessary matters had been followed up.

Leadership, openness and transparency

The practice had a staffing structure, which showed who was accountable for supervising which staff.

Meetings were held regularly and minutes kept and circulated via email to the team. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Examples of minutes seen for team meetings held in April 2015 showed that there was cross communication. These demonstrated there was strong collaboration and support across all staff with a common focus on improving quality of care and people's experiences. Team away days were held every six months.

The practice manager and deputy manager were responsible for human resource policies and procedures. We reviewed a number of policies, induction policy and management of health and safety which were in place to support staff. Two newer staff told us they had received an induction that covered health and safety matters such as fire safety.

Seeking and acting on feedback from patients, public and staff

The importance of patient feedback was recognised and acted upon. The practice used a variety of methods including national and in-house surveys as well as the on-going 'Friends and Family test. The results of patient feedback were monitored regularly with partners and learning disseminated across all staff teams in the various meetings held each month.

There was an active Tavyside patient association and a patient participation group (PPG), minutes showed that the group met with the practice manager and other practice staff every six weeks. Two patient representatives told us that the group had helped the practice team with moving in to the new building, provided support to patients when a new self booking in system was installed, supported staff delivering flu vaccination clinics by offering teas and coffees to patients. The group held a practice awareness week about what services were available there.

The practice was innovative involving the association to hold health promotion events every few months. For example, the association had been made aware of a scheme to promote independence for older people. As a result of this, the association with support from the practice had run a 'driving longer, safer course' and another one was planned for June 2015 due to the success of the previous one. Other examples of awareness events held covered living with diabetes, prostate cancer and promoting altruistic kidney donation. A talk about cardiac rehabilitation was scheduled to take place in June 2015 and the practice had sent out flyers to patients who might benefit from this.

Management lead through learning and improvement

A random selection of staff files showed that annual appraisal were carried out and showed these were done. Staff in interviews confirmed that training needs were identified, present conduct discussed and future plans agreed upon. Written records held on files did not always record this information, which we highlighted during feedback. Nursing staff confirmed they held evidence of professional training and reflection on specific issues to maintain registration with the Nurses, Midwives Council (NMC). Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by a line manager with the appropriate skills, qualifications and experience to undertake this role. For example, the practice had a probationary period and staff confirmed this was followed.

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses

Are services well-led?

Outstanding ☆

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

are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, nurses held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients were reviewed. Mentoring and support was provided where needed to improve skills and accuracy with such testing. The data showed performance was within the national expected range.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **We found that the registered person had not protected people against the risk of fit and proper persons employed. This was in breach of regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Recruitment procedures must be established and operated effectively to ensure that information regarding pre-employment checks is kept regarding persons employed.** **How the regulation was not being met:** • Checks were not being kept to show that staff employed are registered with the staff were registered with the relevant professional body, including the performers list for locum staff. • Proof of identity including a recent photograph was not provided • A full employment history, together with a satisfactory written explanation of any gaps in employment was not provided. • Satisfactory evidence of conduct in previous employment was not recorded as having been sought. • Satisfactory information about any physical or mental health conditions which are relevant to the person's capability were not assessed for all staff.