Compass House Medical Centres

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Compass House Medical Centre was inspected on 12 May 2015. This was a comprehensive inspection.

Overall the practice is rated as outstanding.

Specifically the practice is rated as outstanding for providing responsive and well led services, and good for providing safe, caring and effective care. The practice is rated as outstanding for the care of families, people with long term conditions, and good for the population groups of older people, working age people, vulnerable people, people with mental health issues including dementia.

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

- Patients were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong.
- Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care
- The practice valued feedback from patients and acted upon this and feedback from patients about their care and treatment was consistently positive

We saw several areas of outstanding practice including:

The practice had a young person friendly clinic providing easy access to anonymous chlamydia screening and a condom card scheme called the “C Card Scheme”, a confidential service which enabled patients aged 13-24 years old to get free condoms as well as sexual health information and advice. The local authority informed us that this scheme had achieved a positive impact, decreasing sexually transmitted disease and unwanted pregnancy rates within Torbay.

The practice nominated an executive GP partner on a rotational basis every three years to lead the practice and drive continuous improvement.

The practice carried out virtual clinics for patients with diabetes to support less mobile patients and to reduce patient’s frequency of visits to the practice and also to prevent unnecessary attendance in secondary care.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated good for providing safe services.

Data indicated that the practice was rated the highest in the South Devon & Torbay Clinical Commissioning Group (CCG) area, in relation to safety. Patients were protected by a strong comprehensive safety system, and a focus on transparency and learning when things went wrong.

There were effective safeguarding policies and procedures in place that helped identify and protect children and adults from the risk of abuse. Child protection safeguarding processes were innovative and had improved the management and overview of risk.

Are services effective?

Good

The practice is rated good for providing effective services.

Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run.

The practice had a clinical audit system in place which led to improvements in the care of patients and care and treatment was delivered in line with national best practice guidance.

Information obtained both during and after the inspection showed staff employed at the practice had received appropriate support, training and appraisal.

The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed patients rated the practice higher than others in the CCG for many aspects of care. Feedback from patients about their care and treatment was consistently positive.

We observed a patient centred culture and found evidence that staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on.

Are services responsive to people's needs?

Outstanding

The practice was rated outstanding for providing responsive services.

Summary of findings

Patients commented on how well all the staff communicated with them and that staff were friendly, professional and responsive to their needs. Complaints were managed according to the practice policy and within reasonable timescales.

The practice had responded to the needs of a large number of patients with diabetes by providing an online communication virtual face to face treatment clinic.

The practice recognised the importance of patient feedback and had encouraged the development of a patient participation group to gain patients' views.

Patients said it was easy to get an appointment at the practice and were able to see a GP on the same day if it was urgent.

Are services well-led?

Outstanding ☆

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

The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this had been produced with stakeholders and staff was regularly reviewed and discussed with staff.

The practice acted on staff and patient feedback and made improvements which delivered benefits for staff and patients.

Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.

The practice carried out staff succession planning and future event planning with the engagement of all staff. There was a high level of constructive engagement with staff and patients and a high level of satisfaction.

The practice demonstrated it has worked hard to engage its PPG, and as a result, provided a forward thinking range of services.

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 was rated as good for providing services to older patients.

The life expectancy at 80 years for male patients was higher than the national average of 79 years. Female patient's life expectancy was 83 years which matched the national average. Fifty per cent of the practice population was aged over 65 years and the practice took account of this in its planning. All patients aged over 75 patients had a named GP and every patient over 75 years or their appointed representative could speak to their named accountable GP about their care if they had any concerns.

The practice offered home visits where appropriate and the practice computer system had identified patients who found it difficult to leave their own home to ensure a home visit would be arranged if needed.

The practice worked closely with local nursing homes and residential care homes. Care staff at these homes had been provided with a hotline number to enable immediate access to the practice.

Patients who had been newly discharged from hospital were referred to a GP who arranged contact with them within 72 hours. GPs used a risk based approach which gave priority to those patients on the unplanned hospital admissions list.

People with long term conditions

Outstanding

The practice was rated as outstanding for providing services to patients with long term conditions.

Of the practice population, 71% were registered as having a long term condition compared to the national average of 54%. The leadership of the practice had responded to this in a number of innovative ways. For example, the practice carried out virtual clinics for patients with diabetes to support less mobile patients and to reduce patient's frequency of visits to the practice and also to prevent unnecessary attendance in secondary care.

All patients had been invited for an annual review and the practice held weekly diabetic specialists clinics run by the lead GP for diabetes and his diabetic nurse support team.

The practice maintained active registers of all patients with long term conditions which ensured timely access to care and ongoing review of their condition.

Summary of findings

All patients with breathing disorders were invited for an annual spirometer and Chronic Obstructive Pulmonary Disease check and given personal care plans and issued rescue packs of steroids and antibiotics where appropriate.

Families, children and young people

Outstanding ☆

The practice was rated as outstanding for providing services to families, children and young people.

Same day appointments at 9.30am were available for ill children as well as appointments after school hours, during evenings until 8pm on Tuesdays or booked appointments on Saturday mornings, or at a time requested on the day. Children aged under 11 were seen automatically and not given a telephone appointment unless requested.

There was a section of the website dedicated to young people and a noticeboard solely for young people's health information. The practice had a young person friendly clinic on a Tuesday evening and easy access to anonymous chlamydia screening and a condom card scheme which had been implemented as a result of patient feedback. This was called the "C Card Scheme", a confidential service which enabled patients aged 13-24 years old to get free condoms as well as sexual health information and advice.

There was a strong emphasis on child protection safeguarding at the practice. Practice staff maintained close liaison with the health visiting team, midwives and school nurses including inviting them to monthly child protection safeguarding meetings.

The practice had achieved 98% of planned childhood vaccinations for its 92 registered patients aged under five years, which was higher than the CCG average of 94%.

Children's attendances at hospital accident and emergency units were reviewed by GPs and identified on patient notes to alert GPs to high attendances. This enabled non accidental injuries to be identified and safeguarding action taken promptly if appropriate.

Working age people (including those recently retired and students)

Good ●

The practice was rated as good for providing services to working age people.

The practice provided extended hours appointments on Tuesday evenings until 8pm as well as Saturday mornings from 9am-1pm.

The practice offered an online access to appointments and ordering prescriptions.

Summary of findings

All patients with pre booked appointments are sent text reminders to a mobile phone if they agreed to this service.

The practice believed strongly in health promotion and provided NHS health checks for all patients on request as well as lifestyle advice.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for providing services to patients whose circumstances may make them vulnerable. All relevant patients were flagged on the practice system.

Patients with a learning disability were recorded on a register of these patients, which included details of their carers. They were reviewed annually by a GP.

The practice had patients registered care of the local Brixham Fisherman's Mission, the Marina and a PO Box for those with no fixed abode. The practice supported an itinerant travelling population that visited Galmpton common every spring and frequented the Galmpton practice site during that time.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for providing services to people experiencing poor mental health.

Patients with specific needs had been identified by GPs and flagged up on the computer system to enable the reception team to routinely book them double appointments if required. The clinical team supported patients to self-refer to the depression and anxiety service when appropriate.

The practice had a proforma built into its computer system in order to prompt GPs to cover the bio-psycho-social elements of depression when seeing patients.

The practice offered annual health checks for patients on its mental health registers including those with dementia, and was taking part in the dementia directed enhanced service. The practice recognised those with enhanced needs such as dementia and had an appointed lead GP.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection and a representative of the patient participation group (PPG).

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 experience with us. We collected 22 comment cards which contained detailed positive comments.

Comment cards stated that the practice was friendly, clean and well organised and that the staff who took time to listen effectively. Comments also highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG members. Patients praised the level of care and support they consistently received at the practice and said they received good treatment. Patients told us that the GPs were approachable and professional.

Patients were happy with the appointment system and with the facilities at the practice. They found it easy to get repeat prescriptions and said they thought the website was informative. Patients commented on the building being clean and tidy.

Outstanding practice

The practice had a young person friendly clinic providing easy access to anonymous chlamydia screening and a condom card scheme called the “C Card Scheme”, a confidential service which enabled patients aged 13-24 years old to get free condoms as well as sexual health information and advice. The local authority informed us that this scheme had achieved a positive impact, decreasing sexually transmitted disease and unwanted pregnancy rates within Torbay.

The practice nominated an executive GP partner on a rotational basis every three years to lead the practice and drive continuous improvement.

The practice carried out online face to face communication using virtual clinics for patients with diabetes in order to support less mobile patients and to reduce patient’s frequency of visits to the practice.

Compass House Medical Centres

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Compass House Medical Centres

Compass House Medical Centre provides primary medical services to people living in Brixham and the surrounding areas. The practice provides services to a primarily older patient population (over 50% of patients are aged over 65 years) and is situated in a residential coastal location.

Compass House Medical Centre provided regulated activities from two locations; Compass House Medical Centre, Brixham and Compass House Medical Centre, Galmpton. During our inspection we visited the Brixham location.

At the time of our inspection there were approximately 10,800 patients registered at the service with a team of seven GP partners – four male and three female. The practice manager was also a partner. There were four registered nurses, two phlebotomists and two health care assistants as well as a practice manager, administrative and reception staff.

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.

Compass House Medical Centre is open between Monday and Friday from 8am until 6pm. Appointments were available on Tuesdays until 8pm. Saturday morning appointments were available from 8am – 11.30am.

Patients access out of hours care by calling NHS 111 service.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting Compass House we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local NEW Devon Clinical Commissioning Group.

Good

Are services safe?

Our findings

Safe Track Record

Patients were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong. The practice took a proactive approach to sharing learning from significant events including with other providers, stakeholders and the multidisciplinary team, so that ideas for improvement could be shared.

There was a significant event GP lead and the practice had a system in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred and these were made available to us. Staff were aware of the significant event reporting process and felt comfortable in escalating concerns. Following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. The practice held meetings to discuss significant events at monthly partnership meetings. These included the partners and the three Heads of Department (IT, HR and Finance). Staff explained that these monthly meetings were well structured, well attended and not hierarchical. These meetings were minuted.

There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff. The computer system at Galmpton had been discussed as a significant event and ways to improve its speed were being explored. Staff suggestions had been listened to.

There was a yellow card event system in place. The practice could use this to highlight events which impacted on both primary care and secondary care, in order to highlight an event to the acute NHS Trust. Shared learning took place between the practice and the acute trust. We saw examples of where patients had attended accident and emergency departments where they could have attended the practice instead for treatment. The patients had been advised of this and shared learning taken place between the acute trust and the practice.

There were systems in place to make sure any violent patient alerts, medicines alerts or recalls were actioned by staff. The practice manager was responsible for this, supported by the head of reception. This was done via email, verbally and in meetings.

Learning and improvement from safety incidents

GPs discussed safety incidents daily and also more formally at the monthly clinical meetings.

GPs, nurses and practice staff were able to explain the learning from significant events and incidents. For example, an incident had occurred involving children who were not registered with the practice but their responsible adults were. The practice had suggested the adults take the children to their practice. Following the incident, practice staff had met up with other health professionals and reviewed their actions. The practice reviewed their 'looked after child' policy and introduced a policy which more immediately recognised the needs of children.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and there were policies in place to direct staff on when and how to make a safeguarding referral which staff were familiar with. Named GPs had lead roles for safeguarding older patients, young patients and children. All GPs were trained to Level 3 and all staff had safeguarding training in the last 12 months.

The safeguarding policy had been updated in November 2014 and was reviewed annually or more frequently if required. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them, on the wall in consultation, treatment rooms and staff areas.

Child protection safeguarding processes were thorough and well managed at the practice. The practice had a lead GP for child protection safeguarding who met with local health visitors, school nurses and other professionals on a monthly basis and closely monitored their register of children at risk. Actions discussed and agreed at these meetings were immediately recorded as notes on the patient's record. The practice had a pop up alerts system to flag these with GPs and other health professionals and had implemented a colour coding system which showed levels

of concerns, yellow, orange or red. This system enabled health professionals examining the register to manage risk more effectively, provided a clear outcome to each meeting and the colour coded level of risk was immediately evident.

The practice demonstrated shared learning from significant events with other providers, the entire multidisciplinary team and other external agencies, and took a proactive approach to preventing incidents from happening again and to ensure that ideas for improvement could be shared. Meetings with the health visitor, school nurse, midwife occurred every six weeks.

For example, two 14 year old girls had been requesting emergency contraception where there was concern they were been pressurised into sex against their will by an older man. The police and social services had already been informed. This information was passed on to doctors and nurses at the next clinical meeting a few days later.

Staff felt comfortable in escalating concerns. An example of this related to a young mother attending the practice smelling of alcohol. Whilst her behaviour was otherwise normal, the receptionist passed this information on to the GP safeguarding lead who checked the mother's and child's notes for other incidents, noted this incident and informed the health visitor.

The practice had an up to date written policy and guidance for providing a chaperone for patients which included expectations of how staff were to provide assistance. (A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment). Clinical staff and administration staff at the practice acted as chaperones as required and had received a disclosure barring service (DBS) check. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. Signage was displayed in each of the GP's rooms.

Medicines Management

There was an independent pharmacy on the lower ground floor of the practice. The pharmacy manager attended the practice clinical monthly meetings. There was a good relationship with the practice and the independent on site pharmacy. For example, one of the GPs was mentoring the pharmacist on one of their prescribing courses.

Medication reviews were automatically generated by the practice prescribing software and prescriptions reviewed by a GP. The practice participated in a scheme where a community pharmacist visited care homes and liaised with a GP for medicine reviews. This enabled patients to receive the most up to date and appropriate medicines.

The GPs and nurses were responsible for prescribing medicines at the practice. There were two nurse prescribers employed. Both had completed the accredited training for this role.

The process for repeat prescriptions was simple for patients – through a box in the practice; via email or online. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were notified of health checks needed before medicines were issued.

There were effective systems in place for obtaining, using, safekeeping, storing and supplying medicines. Clear checks and temperature records were kept to strengthen the audit of medicines issued and improve medicine management. All of the medicines we saw were in date. Storage areas were clean and well ordered. Fridge temperatures were monitored daily to ensure that medicines remained effective. We looked at the storage facilities for refrigerated medicines and immunisations, the refrigerator plug was not easily accessible therefore was very unlikely to be inadvertently switched off.

The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patient's medicines were authorised by the prescriber.

There were no controlled drugs (CD) stored at the practice.

Cleanliness & Infection Control

We found high standards of cleanliness and infection control at the practice supported by policies, procedures and training. In addition to daily cleaning by nursing staff, three cleaners were directly employed by the practice. The lead nurse for infection control and head receptionist maintained the cleaning schedules. Patients specifically commented on the building being clean, tidy and hygienic

There was a lead assistant practitioner with responsibility for infection control at the practice. Monthly hand washing audits, quarterly infection control audits and daily spot checks took place.

Good

Are services safe?

An infection control specialist from the local hospital completed a full written review of infection control at the practice. Hand washing signage had been more widely distributed as a result. An external cleaning contractor completed a review of the building and advised the practice about improvements to cleaning schedules around the clinical areas. As a result, the practice had developed new cleaning schedules around these areas within the last six months and further reviews were planned.

Clinical waste and sharps were being disposed of safely and the practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment was within the expiry dates. The emergency first aid equipment was stored in a patient facing area which meant it could be removed by unauthorised persons. This was rectified immediately when we brought it to the attention of the practice manager. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Consultation rooms had examination couches with drawers which had metal handles with sharp edges which posed a potential risk of injury. The provider planned to review their risk assessment of this equipment for their potential to cause injury to patients getting onto the couch.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in September 2014.

The practice friends group had worked closely with the practice to identify equipment required. For example, they had helped the practice obtain a Doppler machine which was used to monitor arterial clogs and veins. The practice had sophisticated cardiac measurement equipment which enabled diagnostics to be completed at the practice, rather than being sent to a hospital, and enabled earlier accurate diagnosis of conditions and results by the GP.

Staffing & Recruitment

Staff told us there were sufficient numbers of staff on duty and that staff rotas were managed well

The practice used a computerised call monitoring system to manage staffing levels to answer the phones.

The practice was excellent at communicating with and developing staff. There was effective team-working and staff engagement. Staff were involved in suggesting areas for improvement and felt well supported by the practice. The practice had been proactive in developing staff by offering access to training and development. For example, four staff had started as receptionists, been developed to health care assistant level and then went on to become a trained nurse or advanced nurse practitioners (ANPs). Workload for part time staff was shared equally and each GP had appointed secretarial administration support

The practice had a low turnover of staff. When they needed a locum they tried to use the same one for continuity and GPs told us they also covered for each other during shorter staff absences.

The practice had recruitment policy and an induction policy in place. Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment and DBS checks were in place for clinical staff and administrative staff who had direct access with patients. Risk assessments had been performed explaining why some clerical and administrative staff had not had a DBS check because their roles did not require one.

Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures. All staff were provided with a staff handbook which was on paper and also on the practice intranet.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a business continuity plan which

Good

Are services safe?

had been reviewed in March 2015 which documented the practice's response to any prolonged events that may compromise patient safety, for example, loss of power, water, computer loss and loss of essential equipment.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

There were environmental risk assessments for the building. For example, legionella tests had been carried out and found the practice to be safe and compliant. Annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been carried out. Health and safety items were a standing agenda item for the monthly staff meetings. There was a designated health and safety officer at the practice.

Arrangements to deal with emergencies and major incidents

Appropriate equipment and medicine was available and maintained to deal with emergencies, including if a patient collapsed. Staff had received relevant training in basic life support, emergency first aid and fire safety.

The practice had an automated external defibrillator (AED) at both sites which was checked daily. An AED is an emergency first aid device used to restart a patient's heart in the event of a cardiac arrest. Staff had been trained to use it within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice followed national best practice and guidelines, for example, National Institute for Health and Care Excellence (NICE) guidance and had formal meetings to discuss latest guidance.

GPs attended the South Devon GPs' forum to participate in presentations on the latest developments; such as safeguarding, diabetes, and minor surgery. Two of the practice GPs were trained to carry out minor operations, for example, the removal of warts.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The IT manager at the practice monitored QOF on a daily basis and completed a written monthly analysis which was reviewed at monthly meetings.

The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. For example, QOF data showed that the practice had 335 patients registered with COPD with a QOF prevalence of 3.081% compared to national average 1.69%. GPs monitored these patients closely via an up to date register. Such data demonstrated that the practice performed well in comparison to other practices within the CCG area. The practice was in the upper quartile for QOF in their CCG area.

The practice had robust care plans in place for patients receiving palliative care. Treatment Escalation Plans (TEP) were in place where relevant and had been used appropriately for patients at the end of their life. There was a lead GP for palliative care who carried out and signposted patients to counselling when required. The practice carried out audits on TEPs to check whether end of life wishes had been respected. The practice held monthly meetings with other health professionals to discuss the top two percent most at risk patients and record agreed actions directly into patient notes.

Management, monitoring and improving outcomes for people

The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including immunisation, diabetes care, cervical screening and travel vaccinations. One of the nurses was in a lead role for travel vaccinations at the practice.

The GPs referred patients to staff in the palliative care community team, who provided support in the patient's home for short term treatment and rehabilitation.

There was a carer's support worker employed by the practice two days a week, to see carers or by telephone outside of those days.

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes.

GPs carried out full and regular clinical audits, for example, optimising prescribing, respiratory prescribing, asthma reviews every six months. These enabled GPs to check accuracy, monitor risk levels and make timely interventions. A prescription audit of pregabalin had been undertaken in May 2015 and was planned to be repeated every six months to ensure a full audit cycle was in place. This audit had found 17 patients required face to face reviews to review their dosages, which had been completed.

Another audit had been undertaken on atrial fibrillation in November 2014 and was planned to be repeated in November 2015. This audit had found 83 patients required a face to face review, which had been completed.

Effective Staffing

There was a strong culture of training and development at the practice. Staff were positive and motivated in their roles.

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The practice planned to become a training practice for new GPs from August 2015 and had made extensive preparations for this. Two of the GPs were qualified trainers for trainee GPs.

Good

Are services effective?

(for example, treatment is effective)

The practice employed a nursing assistant whose dedicated role was to carry out stock control and replenishment, temperature checks and other essential administrative functions normally carried out by nurses. The freed up time of nursing staff.

Nursing staff had received an annual formal appraisal and kept up to date with their continuous professional development programme, and provided documented evidence to confirm this. A process was also in place which showed clerical and administration staff received annual formal appraisal by the senior nurse.

We saw an overarching appraisal schedule. The majority of staff had received an annual appraisal within the last 12 months. There was a plan in place to ensure all staff would receive an annual appraisal within the next three months.

The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. Staff said that they could ask to attend any relevant external training to further their development for example, one member of staff completed a book keeping course in order to accurately maintain the practice accounts.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

There were monthly multidisciplinary team meetings with relevant attached health professionals including social workers, district nurses and palliative care where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings.

There was a district nurse lead associated with the practice and a book maintained at reception to ensure essential information was passed to the district nurses daily.

There was a lead GP for avoiding unplanned hospital admissions. Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, 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 GP lead for diabetes who was working collaboratively with hospital diabetic specialists to receive advance specialist care in the community. The GPs also benefitted by receiving education on the management patients with complex diabetic needs.

The practice had a lead GP for other key areas such as dementia, cancer, children, women's health and elderly care.

Information Sharing

The Out of Hours GPs were able to access patient records with their consent, using a local computer system. Any patients seen overnight by the out of hours' service were flagged up by the practice and reviewed by a GP the following morning. The practice GPs were informed when patients were discharged from hospital which prompted a medication review.

Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed.

There was evidence of written patient consent for procedures including immunisations, injections, and minor surgery.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice acted in accordance with the Mental Capacity Act (2005) (MCA) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject. We were given specific examples by the GPs where they had been involved in best interest decisions and where they had involved independent mental capacity assessors to ensure the decision being made regarding the patient who could not decide themselves, was in the patient's best interest.

Staff had received equality and diversity training every three years, via online e-learning. MCA training had also been completed as e-learning within the last three years.

Health Promotion and Prevention

The practice proactively carried out health checks on an annual basis for all patients aged over 65 years, if the patient consented. Other patients could request annual health checks and these were provided.

Good

Are services effective?

(for example, treatment is effective)

There were regular appointments offered to patients with complex illnesses and diseases. A full range of screening tests were offered for diseases such as prostate cancer, cervical cancer and ovarian cancer.

Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Patients were encouraged to adopt healthy lifestyles and were supported by services such smoking cessation clinics. Breathing disorder, heart disease and asthma clinics all took place here regularly.

All registered patients with learning disability were offered a physical health check each year. The practice had arrangements in place to follow up a lack of response.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

The practice recognised the need to maintain fitness and healthy weight management. The practice worked with local support groups which included referrals to exercise programmes and gyms.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. Website links were easy to locate. The visual display units in each of the waiting areas provided health promotion advice to patients. There were four visual display units at Brixham and one at Galmpton.

Family planning, contraception and sexual health screening was provided at the practice. There was an information board for young people at reception. There were chlamydia testing kits in the lobby by the front door, so patients could obtain one discreetly.

The practice offered a full travel vaccination service but was not a nominated yellow fever centre. This was provided by another practice nearby.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us they felt well cared for at the practice and felt communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs.

There were 125 responses to the 2015 National Patient Survey for this practice. 96% of respondents said the last nurse they saw or spoke to was good at listening to them, compared to the CCG average of 94%.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The four waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an on-going dialogue of choices and options. Comment cards reflected patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and on-going care arranged by practice staff.

90% of survey respondents said that the last GP they saw or spoke to was good at explaining tests and treatments to them. 85% said the last GP they saw or spoke to was good at involving them in decisions about their care. Both of these were higher than the CCG average.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93 % of national survey respondents stated that they were treated with kindness and care. The patients we spoke to and the comment cards we received reflected this.

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

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had responded to the high rates of sexually transmitted diseases and unwanted pregnancy rates in the local area by introducing clinics and the Torbay C Card scheme which offered counselling, free condoms and chlamydia testing kits. The local authority lead for the Torbay C Card scheme advised us that there was evidence from the latest data taken in 2013- 2014 of a decreasing number of patients with sexually transmitted diseases and unwanted pregnancy rates within the local area following the efforts of the practice and other practices in the area deploying the same scheme. Since January 2015 we the practice has processed 28 chlamydia tests kits (which are freely available in the practice lobby) with only one returning positive. This supported the evidence mentioned above.

Quality Outcome Framework (QOF) data showed that the practice had been above the national average in its response to meeting patient's needs. For example, cervical screening rates were 91.46% which was higher than the national average of 81.88%.

Patients told us they felt the staff at the practice were responsive to their individual needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

The practice had a focus on patient satisfaction. This included patient feedback, continuity of care, consistency, access and GP/ patient ratio. Many of the patients at the practice were elderly and liked to speak to their own GP on every occasion. The practice had a system in place to achieve this within an hour of the request.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours, or 48 hours if test results were routine. Patients said they had not experienced delays receiving test results.

A patient participation group (PPG) had been established in 2011. We spoke with a member of this group who told us the PPG had been consulted about proposed changes and improvements to the practice including information display screens in each of the four waiting areas. The PPG members said they were encouraged to contribute suggestions.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The practice had identified young people as a hard to reach group in a predominantly older patient population. The practice actively engaged with young patients through an online virtual forum and a notice board designed specifically for young patients.

The number of patients with a first language other than English was low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The patient participation group (PPG) was working to recruit patients from each of the six population groups to reflect the makeup of the practice.

There was no evidence of discrimination when making care and treatment decisions.

Access to the service

The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. There was a working lift in the building. If the lift was out of order, alternative treatment rooms were available for patients on the ground floor.

The practice had a lobby area with seating inside the main entrance, yet separate to the main waiting room. The practice security arrangements ensured that patients who arrived earlier than the 8am opening time could still access this lobby area via the automatic doors to shelter from adverse weather. Patients with babies in pushchairs and older patients told us they very much appreciated this kind consideration.

The practice had introduced a telephone triage service, together with Saturday morning opening and late night Tuesday opening to increase the flexibility of access to appointments. Numbers and outcomes of calls were

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

monitored continually by staff in a flight deck style control room designed for this purpose, on a visual display unit. The system of appointment workload monitoring in the control room allowed the practice to respond to high or increased demand and was a form of continuous audit. The practice demonstrated the positive impact of this system by reduced use of the out of hours' service and positive patient survey results.

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. 22 comment cards, discussions with patients and feedback indicated that patients were happy with the arrangements for access.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication. Patients were happy with the appointment system and said they could get a same day appointment if necessary.

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by a poster displayed in the practice, on the website and on the telephone answering message.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns which stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. If they concerned clinical matters a GP would make an appropriate response in conjunction with the practice manager.

Patients told us they had no complaints and could not imagine needing to complain. All patients we spoke with were aware of how to make a complaint and said they felt confident that any issues would be managed well.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the practice welcomed patient opinion by sharing ideas, suggestions, views, and concerns.

Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at the clinical meetings held every month. Evidence showed that the practice recorded complaints and any learning points from them appropriately.

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 leadership, governance and culture at the practice was used to drive and improve the delivery of high-quality person-centred care.

Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. The practice recently held two staff meetings in the evening to capture thoughts on how the practice should move forward in four targeted areas; financial management, practice management, patient satisfaction, and practice development. Ideas captured from staff during these two evenings had been implemented, for example, replacing cloth tea towels with disposable towels saving the practice money which could be used for patient care.

Subsequently, the practice had set up four staff task groups to examine the key areas of future direction, financial stability, organisational development and patient satisfaction. These areas took into account staff succession planning, business planning and a strategic vision of the future. Each task group included a GP, a head of department and a front line member of staff.

The practice engaged frequently with the PPG to gain input to future developments and improvements. The PPG told us they had a strong working relationship with the practice, which enabled patient feedback to be heard and acted upon.

Organisational development was strong within the practice. The practice management had sought staff feedback on succession planning for every role at the practice, on the management structure, on future options and timelines. Detailed written plans were in place as a result. The impact of this was that staff were engaged in the future of the practice and its continuous improvement.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and many staff had worked at the practice for many years and were positive about the open culture.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Governance Arrangements

The practice nominated an executive partner responsible for chairing meetings and leading the practice, which rotated between the seven partners every three years. This democratic system enabled innovation and openness to flourish. Staff told us that the partners were always striving to improve the practice for patients.

GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. The practice held partnership meetings once a month; attended by the practice manager, GPs, heads of department and any operational staff who wished to attend. The practice held a monthly staff meeting which was timed to follow on the Thursday after the partnership meetings, all staff were invited. Standing items included child protection, CQC inspections, future plans, staff training, staff feedback and staff pensions. These issues were then followed up more formally at three monthly clinical meetings where standing agenda items included significant events, near misses, complaints and health and safety.

Leadership, openness and transparency

The structure of leadership was clear. There were seven partner GPs and a practice manager partner. The partners were supported by heads of department for finance, human resources and IT. There was a lead GP for key areas and staff knew who these were. The practice had achieved 81% of its QOF target in 2013-2014 and 95% of its QOF target in 2014-15 which was higher than the CCG and national average.

Staff spoke about effective team working, clear roles and responsibilities and talked about a supportive non-hierarchical organisation.

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

The practice had a patient participation group (PPG), which had been set up 2011. There were approximately fifty active members and the PPG was working to get members from

Are services well-led?

Outstanding ☆

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

each of the population groups. There was an advert on the practice website for the PPG. The PPG virtual group was very active. Members of the PPG met with practice management staff on a quarterly basis.

The PPG member we spoke to said the practice encouraged patient feedback and involvement. We were given a number of examples of changes that had been made as a result of PPG and patient feedback. For example; timing and content of patient surveys; improved information about appointment booking; access to the lobby area before 8am; improvements to the patient information screen.

In addition to the PPG, the practice also had 'The Friends Group' which had been active for around 20 years. This group raised money for the practice which led to, for example, the purchase of blood test machines, a Doppler diabetes testing machine. Some patients had been taken out on trips from funds raised via Friends Group to help decrease social isolation and improve their well-being.

Acting on staff feedback, the practice employed a nursing assistant to take over responsibility for stock control, temperature checks and other essential administrative functions normally carried out by nurses which allowed nurses more time for patient appointments.

Management lead through learning & improvement

The leadership of the practice used innovation to achieve continuous improvement. For example, the introduction of a telephone triage service, together with Saturday morning opening and late night Tuesday opening to increase the flexibility of access to appointments. Numbers and outcomes of calls were monitored continually by staff in a flight deck style control room designed for this purpose, on a visual display unit. The system of appointment workload monitoring in the control room allowed the practice to respond to high or increased demand and was a form of continuous audit. The practice demonstrated the positive impact of this system by reducing the use of the out of hour's service and by the positive patient survey results.

The practice had an innovative approach to the development of staff and a very supportive approach to staff development. Staff provided us with numerous examples of how the practice had provided them with the time and resources to achieve new roles and higher qualifications.

Monthly staff meetings included training on updates to policies and procedures. Records of monthly meetings showed discussions included current topics, reviews of incidents and any newly released national guidelines and the impact for patients. The practice had set time aside for continuous professional development for staff and access to further education and training as needed on a case by case basis.