# Devon Square Surgery

## 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? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Devon Square Surgery on Wednesday 12 August 2015. Overall the practice is rated as good.

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

- There was a safe track record and 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. Medicines were well managed and the practice had good facilities and was well equipped to treat patients and meet their needs
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- 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, with urgent appointments available the same day.
- There were clear recruitment processes in place. Staff had received training appropriate to their roles and any further training needs had been identified and planned
- The practice was well organised and there was a clear leadership structure. The practice proactively sought feedback from staff and patients, which it acted on.

We saw two areas of outstanding practice for older patients and those identified as being frail:

- The practice had been instrumental in the development of a model in Newton Abbot named '1 care home, 1 practice' . The model allocated a

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designated GP who cared for the majority of residents in a care home which meant the GP were able to offer regular review visits and develop strong relationships with the residents, managers and staff. Care home staff said this had improved communication between the GP and care home and had given patients reassurance that they knew the GP that visited them.

- The practice were also actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover at nights and during the weekend for the top 2% most frail patients. The GPs had collaborated so that all the local GPs involved in this have access to the other practice's computer records, meaning they provided a greater continuity of care and were more informed about the patients they were seeing. Anecdotal evidence was that this scheme had reduced hospital admissions. Formal data was being collated.

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

Importantly the provider should:

- Provide evidence of a system to ensure that curtains in consulting rooms are cleaned or changed at least once every 6 months.

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

**Professor Steve Field** CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed although some minor improvements to infection control processes were needed.

**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 the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

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

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. As a result the GPs were involved in two schemes. One where a GP was

# Summary of findings

the single designated GP for a named care home and another was where the GPs worked with other GPs in the locality to provide an out of hours service for the top 2% frail patients in an effort to reduce hospital admissions.

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 was shared with staff and other stakeholders.

**Are services well-led?**

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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.

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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice took part in a scheme in Newton Abbot named '1 care home, 1 practice.' The model allocated a designated GP who cared for the majority of residents in a care home which meant they were able to offer regular review visits and develop strong relationships with the residents, managers and staff. Feedback from care homes showed that continuity of care and communication had improved as a result of this.

### People with long term conditions

Good

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

Longer appointments and home visits were available when needed. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority and monitored more closely. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Should these patients be identified as being frail the GPs provided out of hours cover on the weekend as part of the 8-8 initiative.

### Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E

# Summary of findings

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, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

**Working age people (including those recently retired and students)**

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Working age people were able to access appointments from 7am in the morning and told us they found this useful.

**People whose circumstances may make them vulnerable**

Good

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

The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. Staff had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. Longer appointments were offered to patients who may need more time to discuss or understand their care, such as some people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

# Summary of findings

Data showed that 94% of people experiencing poor mental health had received an annual physical and mental health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Staff carried out care planning for patients with dementia to ensure details of their specific care needs were discussed and recorded.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

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## What people who use the service say

The national GP patient survey results published in July 2015 showed the practice had come third out of six within the locality and were comparable with the CCG average or higher than average compared to national averages. There were 107 responses.

- 97% find it easy to get through to this practice by phone compared with a CCG average of 80% and a national average of 73%.
- 95% find the receptionists at this practice helpful compared with a CCG average of 90% and a national average of 87%.
- 74% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 64% and a national average of 60%.
- 90% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 90% and a national average of 85%.
- 93% say the last appointment they got was convenient compared with a slightly higher CCG average of 95% and a national average of 92%.
- 93% describe their experience of making an appointment as good compared with a CCG average of 81% and a national average of 73%.
- 71% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 72% and a national average of 65%.
- 66% feel they don't normally have to wait too long to be seen compared with a CCG average of 67% and a national average of 58%.

As part of our inspection we also asked for patient feedback prior to our inspection. We received 37 comment cards which were all positive about the standard of care received. Comments from patients were detailed and referred to staff as being courteous, professional, caring and considerate. Patients said the treatment they received was excellent, good and caring and stated that they appreciated the clean and tidy facilities. Patients said the GPs listened and provided a good service. However there were improvements that some patients felt could be made. Three patients told us verbally or in writing that they wanted the practice to be open at more convenient times.

We spoke with 23 patients on the day of our inspection and found their views aligned with our findings. Patients were positive about the practice and the treatment they received. Two patients raised minor concerns over not seeing their preferred GP and wanting the practice to be open at more convenient times. Other concerns included frustrations over the inability to get advance appointments i.e. enquiring for an appointment the next day but being told only to ring the following morning at 08.30am. Patients appreciated the efficient repeat prescription process and said that they were treated with respect by the staff, who they described as being kind, caring and efficient. Patients said they had enough time with the GPs and nurses and said they were listened to and involved in their care. Patients were satisfied with the cleanliness and facilities at the practice and had not found any need to complain.

We saw the results from the practice friends and family test carried out between January 2015 and July 2015. There were 17 results of which 12 respondents were extremely likely to recommend the practice; one respondent was likely to; two did not state a decision and two were unlikely. Comments linked to the unlikely decision related to frustrations over the appointment system.

## Areas for improvement

**Action the service SHOULD take to improve**

- Provide evidence of a system to ensure that curtains in consulting rooms are cleaned or changed at least once every 6 months.

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## Outstanding practice

- The practice had been instrumental in the development of a model in Newton Abbot named '1 care home, 1 practice' . The model allocated a designated GP who cared for the majority of residents in a care home which meant the GP were able to offer regular review visits and develop strong relationships with the residents, managers and staff. Care home staff said this had improved communication between the GP and care home and had given patients reassurance that they knew the GP that visited them.
- The practice were also actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover at nights and during the weekend for the top 2% most frail patients. The GPs had collaborated so that all the local GPs involved in this have access to the other practice's computer records, meaning they provided a greater continuity of care and were more informed about the patients they were seeing. Anecdotal evidence was that this scheme had reduced hospital admissions. Formal data was being collated.

# Devon Square Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor, a practice nurse specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

## Background to Devon Square Surgery

Devon Square Surgery was inspected on Wednesday 12 August 2015. This was a comprehensive inspection.

The main practice is situated in the Devon town of Newton Abbot. The practice provides a primary medical service to approximately 8,500 patients of a diverse age group but with a higher percentage of older people. The practice was a training practice for doctors who are training to become GPs and for medical students from the Penninsula medical school.

There was a team of four GP partners and one salaried GP within the organisation. Partners hold managerial and financial responsibility for running the business. There were three male and two female GPs. The team were supported by a practice manager, an office manager, three practice nurses, two health care assistants and additional administration staff.

Patients using the practice also had access to community staff including community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open from Monday to Friday. The reception teams take phone calls between 8:30 and 6pm. Outside of these times there was a local agreement that the out of hours service would take phone calls. Appointment times are 7am - 12:30 and 3pm -5.45pm on Mondays and Wednesdays and 9am – 12.30 and 3pm -5.45pm on Tuesday, Thursday and Fridays. GPs also perform home visits and telephone consultations between 12.30 and 3pm.

When the practice was shut he practice directed patients to an out-of-hours service. This local agreement was also used for training days held at the practice. However, the GPs at the practice was actively involved in a local ‘8-8 initiative’, whereby local Newton Abbot GPs provide an out of hours cover on the weekend for the top 2% most frail patients.

The practice offered a range of appointment type. Half of the appointments were 'book on the day' appointments, 30% were pre bookable and the rest were reserved for telephone consultations. Telephone consultations could be booked well in advance if needed. The practice ran a personal list system, which meant that wherever possible patients would see the GP of their choice. However, if that GP was not available, patients were able to see one of the other GPs.

## 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

# Detailed findings

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 and treatment, we always ask the following five questions:

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We also received four responses from members of the patient participation group.

We carried out an announced visit on 12 August 2015. During our visit we spoke with a range of staff and spoke with 23 patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 37 comment cards where patients and members of the public shared their views and experiences of the service.

Following the inspection visit we also spoke with two care home managers after the inspection.

Good

# Are services safe?

## Our findings

**Safe track record and learning**

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons learnt were shared to make sure action was taken to improve safety in the practice. For example, a prescribing error occurred, the GP followed the process at the practice, shared with colleagues and informed the clinical commissioning group. The patient was also given an apology and further prompts were introduced to prevent reoccurrence.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

**Overview of safety systems and processes**

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. For example, the policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The GPs had trained to level 3 to ensure that they all had suitable knowledge.

A notice was displayed in the waiting room, advising patients that chaperones were available if required. All staff that acted as chaperones was trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). There were systems in place to ensure medicines requiring refrigeration were stored at the correct temperatures. These systems included daily fridge temperature recordings and policies to maintain the cold chain so that medicines were safe to be given to patients. The practice used prompts for prescribing and regular medicine audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The practice told us they were performing well in comparison to other practices in the area. Prescription pads were securely stored and there were systems in place to monitor their use.

Recruitment checks were carried out and the two files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Assurances that suitable pre employment checks had been performed were also obtained for locum staff.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Administration staff told us they used a rota system to cover the work and ensure they maintained skills in more than one area of work.

The practice was clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with current practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The last audit had been performed in June 2015

and had highlighted the need to replace chairs in clinical areas with chairs that could be easily wiped. We saw that clinical treatment rooms had flooring which were seamless and smooth, slip-resistant, and easily cleanable. Clinical rooms had disposable curtains with a programme to show when curtains should be replaced. However, consulting rooms contained non disposable curtains used for screening. Staff explained that these were cleaned on a regular basis but were unable to provide evidence of a system to risk assess and mitigate risks from cross infection.

There were areas of the practice which were in need of replacement and repair. For example, wooden sink surrounds and splash backs which were not easily cleanable. The staff explained that this had been identified and was part of a long term plan to upgrade. One desk in a GPs consulting room had a top which would not be easily cleaned. The GP gave reassurances that this risk would be assessed and any risk reduced.

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the office areas. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use. For example, the last PAT (portable electrical safety testing) had been performed in December 2014. Clinical equipment had been tested for safety and performance as part of a rolling maintenance programme. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. The last legionella testing was performed in June 2015. Children's toys were located in the waiting room next to a radiator, which could present a scald/burn risk. At the time of the inspection the radiator was not on and were given assurances that processes were in place to cover the radiator to minimise the risk of burns and scalds.

**Arrangements to deal with emergencies and major incidents**

There were panic buttons in reception areas and an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room.

The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. Staff explained that weekly checks were performed but could not produce evidence that this occurred.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

**Management, monitoring and improving outcomes for people**

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were close to the 100% of the total number of points available, with no exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from the health and social care information centre showed the following:

- Performance for diabetes related indicators was better than the CCG and national average. For example, the practice scored 96.75% for recording a foot examination on patients with diabetes. This compared with a national score of 88.35%
- The percentage of patients aged 75 or over with a history of fractures who were being treated with bone sparing medicines was higher than national average. For example the practice scored 100% compared to the national average of 81.27%
- Performance for mental health related indicators was better than the national average. For example 94% of patients with a recorded mental health illness had an agreed care plan in place. This compared well to the national average of 86.04%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We were shown 11 clinical audits completed in the last two years, Six of these were completed audits where the improvements made were implemented, repeated and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, an audit of patients with a specific type of diabetes had indicated the need to blood tests to monitor the conditions. A repeat audit showed that the number of patients who continued to be at risk had reduced. Other learning from audits included education, prompts for staff and consideration of purchasing specialised clinical equipment.

**Effective staffing**

Staff had the skills, knowledge and experience to deliver effective care and treatment.

The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. Clinical staff and locum GPs were also supported according to their need and ability. All staff were issued with a staff handbook.

Staff told us they felt supported and had access to further education and training. Learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. Staff explained there was mutual respect shown at the practice and all colleagues were supportive and offered guidance where required. All staff had received an appraisal within the last 12 months.

Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. Registered nurses had received further education to keep their skills and knowledge up to date. For example, they had received updates for cervical screening, diabetes, ear irrigation and immunisations.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results.

Good

# Are services effective?

## (for example, treatment is effective)

For example, the phlebotomist showed us the system used to request, complete and follow up blood tests. Information such as NHS patient information leaflets were also available within treatment rooms and waiting areas. All relevant information was shared with other services in a timely way, for example when patients were discussed at the multidisciplinary meetings. Other examples included, where information was shared with out of hours providers or with the GPs who were providing out of hours cover for the top 2% frail patients as part of the scheme. There were systems to ensure any referrals were completed and audits performed to ensure the process was effective.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that the practice held a range of meetings to discuss patient. These included six to eight weekly 'blue bed' multi-disciplinary team meetings where vulnerable patients and care plans were reviewed and updated. The practice also held three monthly palliative care meetings with members of the multidisciplinary team. The GPs also held weekly internal primary care meetings where staff could discuss patient care.

**Consent to care and treatment**

The practice used templates and prompts when gaining consent for procedures including ear syringing, cervical smears, immunisations and blood. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance.

Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

We were told that the process for explaining risks and seeking consent for minor surgery procedures was performed verbally by the GP. We were not provided with evidence of a system to show that this took place. However, by the end of the inspection process the GPs had produced a written draft minor surgery consent form which included the risks, benefits and possible side effects. The practice manager explained this was planned to be introduced immediately. Patients told us their consent was obtained prior to any procedure being performed.

**Health promotion and prevention**

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

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81.12%, which was comparable with the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were better than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 84% to 100% and five year olds from 93.3% to 96.7%. These were also comparable to CCG and national averages.

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

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private space to discuss their needs.

All of the 37 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We received comments from four virtual members of the patient participation group (PPG) and also spoke with a member of the PPG on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 95% said the GP was good at listening to them compared to the CCG average of 93% and national average of 89%.
- 96% said the GP gave them enough time compared to the CCG average of 91% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 99% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 92%.
- 96% described their overall experience as good compared with the CCG average of 90% and national average of 85%

**Care planning and involvement in decisions about care and treatment**

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

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

- 98% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 81%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. We spoke with one Polish patient who said they had been offered the service but had declined.

**Patient and carer support to cope emotionally with care and treatment**

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

# Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support or counselling service.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice was involved in two initiatives set up by GPs in the town and the CCG.

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

- The practice offered early morning appointments from 7am on a Monday and Wednesday morning for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or for patients who would benefit from these.
- There were disabled facilities, hearing loop and translation services available.
- The practice ensured any patients with mobility issues could be seen in a ground floor consulting room. All treatment rooms were situated on the ground floor.

**Access to the service**

The practice was open from Monday to Friday. The reception teams took phone calls between 8.30am and 6.00pm. Outside of these times there was a local agreement that the out of hours service would take phone calls. Appointment times were between 7am - 12:30 and 3pm -5.45pm on Mondays and Wednesdays and 9am – 12.30 and 3pm -5.45pm on Tuesday, Thursday and Fridays. GPs also performed home visits and telephone consultations between 12.30 and 3pm.

When the practice was shut he practice directed patients to an out-of-hours service. This local agreement was also used for training days held at the practice. However, the GPs at the practice were actively involved in a local '8-8 initiative', whereby local Newton Abbot GPs provide an out of hours cover on the weekend for the top 2% most frail patients.

The practice offered a range of appointment type. Half of the appointments were 'book on the day' appointments, 30% were pre bookable and the rest were reserved for telephone consultations. Telephone consultations could be booked well in advance if needed. The practice ran a personal list system, which meant that wherever possible patients would see the GP of their choice. However, if that GP was not available, patients were able to see one of the other GPs.

All of the patients we spoke to on the day were able to get appointments when they needed them but two expressed frustration with getting pre bookable appointments. Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mostly comparable with or slightly lower than local and national averages. For example:

- 73% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 97% patients said they could get through easily to the practice by phone compared to the CCG average of 80% and national average of 73%.
- 93% patients described their experience of making an appointment as good compared to the CCG average of 81% and national average of 73%.
- 71% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.

**Listening and learning from concerns and complaints**

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

We saw that information was available to help patients understand the complaints system. For example, we saw posters displayed in waiting areas and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. We spoke with one patient who had made a complaint and saw that this had been handled in a timely way. The response was open and transparent about how the practice would take this forward to improve the service. We saw a spread sheet which was used to monitor any trends and used to raise any lessons and identify any action to improve the quality of care. For example, one complaint raised by a relative of a patient had resulted in the practice

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

staff meeting and apologising to the relative. Further actions included offering a carers check to the relative and review of the patients care plan to ensure care was appropriate.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

The practice had a clear vision to 'deliver high quality compassionate care from a committed happy stable staff base whilst continuing to pick the best for patient care'. This practice had a mission statement which was displayed in the waiting areas. The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

**Governance arrangements**

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. For example, all policies were accessible by staff on the intranet. Staff explained that any changes were discussed at their weekly team meetings.
- A comprehensive understanding of the performance of the practice was communicated to all staff at the weekly meetings and annual away days.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements. For example, audits of the cervical screening programme and two week wait system used.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, annual environmental risk assessments were performed.

**Leadership, openness and transparency**

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. Systems were in place to prioritise safe, high quality and compassionate care, through structured meetings, IT systems and information gathering. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that weekly team meetings were held and that there was a non-hierarchical and open culture within the practice. Staff explained that they had the opportunity to raise any issues at team meetings and felt confident in doing so and were supported if they did. For example, a member of the administration team had requested a weekly team meeting like clinical staff had access to do. We also noted that team away days were held every year where the emphasis was on team building. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The practice had been awarded investors in people (IIP) for a number of years. IIP was established by the UK Government to help organisations use a management framework to champion best practice in people management and equip organisations with the tools to succeed through an objective assessment to determine performance.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG. The PPG representative we spoke with had been a member for the past two years and met several times a year with the Practice Manager. Other PPG members were a 'virtual group' contacted by the practice manager by email. The one face to face member was a keen advocate for Dementia Carers and had given talks to staff at the practice which had been positively received and given staff a better understanding of both carer and patient needs.

The PPG member had assisted the Practice manager with promoting the practice and encouraging other patients to join. The four members of the virtual group were also positive about their involvement and described the practice management as receptive, open to suggestions and spoke of times where they were thanked, by way of a card, for help with the GP training programme.

The practice had also gathered feedback from staff through annual staff surveys, through staff away days and generally

# Are services well-led?

Good

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

through staff meetings, appraisals and informal discussion. Staff explained that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

**Innovation**

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, The practice had been instrumental in the development of a scheme in Newton Abbot called '1 care home, 1 practice' and were also actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover on the weekend for the top 2% most frail patients.

The practice had been involved in medical teaching for many years and usually had two GP registrars working. (GP registrars are fully qualified doctors with hospital experience.) Patient participation with registrars was entirely voluntary. Patients were notified and able to decline the appointment at any time.

The practice also supported medical students from the Peninsula Medical School. The practice had received a positive re-accreditation report from the university deanery in July 2015.