

Beacon Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

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 Beacon Medical Centre on 11 April 2017. Overall the practice is rated as good with requires improvement in the well led domain..

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. Staff were encouraged and actively supported to develop their roles.
- There were GPs with a special interest (GPwSI) in dermatology and orthopaedics which meant patients could receive specialist treatment at the practice.
- The practice employed a pharmacist one day a week who performed roles to assist the GPs at the practice. These roles included patient medicine reviews and audit.
- Results from the in house patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was not readily available in written format and difficult to access online. However, improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Patients said they appreciated the minor injury service provided by the practice.
- The main practice had good facilities and was well equipped to treat patients and meet their needs. This included a designated operating theatre where carpal

Summary of findings

tunnel surgery and skin cancer surgery was performed. The GPs were in discussions with NHS estates regarding the development and upgrade of the branch site as they recognised improvements were required.

- There were age appropriate toys and books in the waiting room and an interactive flooring area that was popular with children.
- Recruitment was well managed and detailed systems were efficiently used to monitor staff recruitment and employment issues.
- The prescriptions team at the practice worked closely with the local pharmacies to ensure blister packs were provided for older people with memory problems.
- One of the GPs was a dementia champion and used their knowledge and experience to make early diagnosis and referrals as necessary.
- One of the GPs sits as a trustee on a voluntary basis at the local Memory Café and personally led the work to secure an Admiral Nurse for the town, now in place. (Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia). Staff at the practice supported fundraising for this service.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The practice were proactive in the care of patients with dementia. One of the GPs was a dementia champion and had used their knowledge and experience to make early diagnosis and referrals as necessary. 79.1% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was better than the national average (30-75%). Another GP had acted as a trustee on a voluntary basis at the local Memory Café and supported fundraising to secure an Admiral Nurse for the town, now in place.

The areas where the provider should make improvement are:

- Review systems and records so they reflect the discussions and actions taken to ensure staff who do not attend the significant event meetings are fully aware of learning and outcomes.

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?

The practice is rated as good for providing safe services.

Good



- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice; however, records did not always demonstrate clearly the detail of the discussion, findings and learning that had taken place or whether the issue had been reported externally. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Detailed systems were efficiently used to monitor staff recruitment and employment issues.
- Medicines were well managed at the practice.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Unpublished data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance and had systems in place to update the team when changes occurred.
- The practice employed a pharmacist one day a week who offered advice to patients, conducted medicines reviews, checked medicine safety and perform audits of medicines to ensure the correct processes and checks were being followed.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment. Staff were encouraged and actively supported to develop their roles.

Summary of findings

- Patients were able to access carpal tunnel surgery and skin cancer surgery at the operating theatre within the practice. This service was provided by GPs with a special interest (GPwSI) employed at the practice. These included dermatology GPwSI and orthopaedic GPwSI.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved. With patient consent, information from patient records was shared with out of hours providers, the ambulance trust and local acute hospital staff.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the in house patient survey showed patients rated the practice highly for several aspects of care.
- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Carers at the practice were provided with written and verbal information and were invited to a carers assessment.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an urgent appointment but added they sometimes had to wait a little longer to get an appointment with the GP of their choice although there was continuity of care. Parents said it was easy to get their child an appointment to see the GP.
- Patients appreciated the minor injury service provided by the practice.

Summary of findings

- The practice at the main site had good facilities and was well equipped to treat patients and meet their needs. This included a designated operating theatre where carpal tunnel surgery and skin cancer and dermatology surgery was performed.
- The GPs were in discussions with NHS estates regarding the development and upgrade of the old site which was currently being used as a branch surgery.
- Complaints were managed effectively and patients said they felt there was no need to complain although were not always aware of how to complain. Information about how to complain was accessible on-line, in patient leaflets and on the TV screens in waiting areas. Written information was also available within the waiting areas. Examples of the complaints reviewed showed the practice responded quickly to issues raised and learning from complaints was shared with staff.
- All care homes had a direct line telephone number so that they could contact the practice without delay when needed.

Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. Staff said the practice was a good place to work.
- The practice had policies and procedures to govern activity and held regular governance meetings. Significant events were discussed with all staff concerned and records kept of these meetings. However some records did not always reflect the detailed discussion or action and learning taken following significant events.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.

Good



Summary of findings

- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the active patient participation group. For example, action taken regarding dissatisfaction regarding ease of access to appointments.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients. For example, offering carpal tunnel surgery and skin cancer surgery at the practice.

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

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

- There was a higher than average elderly population at the practice (40% of patients are over 65 and 21% were over 75 years of age.)
- The GP practice had developed a proactive and personalised programme of care and support, which was tailored to the needs and views of older people registered with the practice. Each patient had a named GP but were also able to see other GPs at the practice.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice employed a duty personal assistant who supported the duty GP by contacting patients to update and help patients where appropriate.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. They involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Care plans were in place for patients at high risk of unplanned admission and these were shared with local out-of-hours providers, the ambulance services and emergency department. Regular hospital avoidance of admission meetings were held.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- Older patients and carers were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible
- The GPs undertook a daily ward round at the hospital (situated next to the branch surgery in Sidmouth) during the week and were responsive to urgent requests from the hospital for patient care such as medicine changes and X-ray requests.
- The practice had responsive systems in place for the care of their patients in care homes. The practice manager and one of the GPs visited six care homes in the area to discuss and review the care provided to their patients with a view to find ways to

Outstanding



Summary of findings

continually improve the service. As a result of these meetings the care homes were given a direct line telephone number so that they could contact the practice without delay when needed.

People with long term conditions

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

Good



- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- Sid Valley Practice had signed up for the local shared care record project in 2016. This enabled health and care professionals such as Devon Doctors, the ambulance service and Royal Devon & Exeter hospital to view relevant information about the patients.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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

Good



- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.

Summary of findings

- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- There were age appropriate toys and books in the waiting room and an interactive flooring area that was popular with children.

Working age people (including those recently retired and students)

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and Saturday appointments.
- The staff were proactive in calling patients into the practice for health checks. These included offering referrals for smoking cessation, providing health information, routine health checks, carers assessments and reminders to have medicine reviews. This gave the Practice the opportunity to assess the risk of serious conditions on patients which attend. The Practice also offered age appropriate screening tests including cholesterol testing.

Good



People whose circumstances may make them vulnerable

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

- The practice provided care and treatment to patients living in vulnerable circumstances including homeless people, refugee families and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients who needed them.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients and their carers about how to access various support groups and voluntary organisations.

Good



Summary of findings

- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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)

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

- The practice carried out advance care planning for patients living with dementia.
- 79.1% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was better than the national average (30-75%).
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs. A pharmacist had been employed by the practice to assist with this role.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The prescriptions team at the practice worked closely with the local pharmacies to ensure blister packs were provided for older people with memory problems.
- One of the GPs was a dementia champion and used their knowledge and experience to make early diagnosis and referrals as necessary.
- One of the GPs sits as a trustee on a voluntary basis at the local Memory Café and personally led the work to secure an Admiral Nurse for the town, now in place. Staff at the practice supported fundraising for this service.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 but did not include this new organisation. However, the practice had carried out its own patient survey in April 2016.

The practice used an online survey to obtain patient views. Over 800 results were collected. Results were mainly positive but contained dissatisfaction with ease of or timely appointment with the GP of choice. Results had been reviewed by the practice manager and patient participation group. The practice manager had reviewed appointment availability which had been noted to have improved at the latest meeting in March 2017. The practice had also employed a clinical pharmacist to help increase the security and safety of medicines and provide patients with additional support and information. Patient survey results also highlighted that patients were not always aware of how to make a complaint. Comments included that there had not been a need or that patients would initially enquire at the reception desk.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received eight comment cards which were all positive about the standard of care received. Patients referred to staff being polite, professional and caring and treatment being excellent, responsive and efficient.

We spoke with 11 patients during the inspection. All 11 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Patients said they liked the new practice and said it was bright, clean and accessible. Patients said they hoped the branch surgery in the town centre would remain as this was often more convenient to attend. Patients said it was easy to make an appointment and they could see a GP when needed but sometimes had to wait a little longer to see the GP of choice. Patients told us they were not kept waiting too long to see the nurse or GP but added that the announcement system was not always clear. We spoke with one child who liked the toys at the practice and said the interactive floor was very good. Patients were not always aware of how to make a complaint at the practice, although added that there had not been a need to do this.

Areas for improvement

Action the service **SHOULD** take to improve

- Review systems and records so they reflect the discussions and actions taken to ensure staff who do not attend the significant event meetings are fully aware of learning and outcomes.

Beacon Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a CQC Assistant Inspector and a practice manager specialist adviser.

Background to Beacon Medical Centre

Beacon Medical Centre, also known as Sid Valley Practice is located on the outskirts of Sidmouth. There is a branch surgery; Blackmore Health Centre which is also located in the town centre of Sidmouth. The practice supports approximately 15,000 patients.

The practice population is in the tenth less deprived decile for deprivation. In a score of one to ten the lower the decile the more deprived an area is. There is a practice age distribution of male and female patients equivalent to national average figures. Average life expectancy for the area is higher than national figures with males living to an average age of 83 years for males and females to 86 years.

There are 11 GP partners, five of which are female and six are male. There are three salaried GPs (one male and two female). Together they provide 78 patients sessions per week (just under 10 whole time equivalent staff). The GPs are supported by a practice manager, an assistant practice manager, an office manager, a human resources manager, eight nurses, seven healthcare assistants, and 35 additional administrative and reception staff.

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

The practice is a teaching and training practice. GPs work with the university of Exeter Medical School and provide support for 4th and 5th year medical students. One of the GPs provides support and training for FY2 doctors (A Foundation doctor (FY1 or FY2 also known as a house officer) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.) who are working at the local community hospital.

The main practice, Beacon Medical centre, is open from Monday to Friday, between the hours of 8am and 6pm in line with local arrangements with the out of hours provider between 6 and 6.30pm. The branch practice, Blackmore Health Centre, is open every Monday, Wednesday, Thursday and Friday, between the hours of 8.30am until 1pm and then 2pm until 5pm and every Tuesday and between 8.30am and 1pm. Patients can book routine appointments up to eight weeks in advance. If a patient cannot get a routine appointment with their own GP within 3 weeks then they are offered an alternative GP if they wish.

During evenings and weekends, when the practice is closed, patients are directed to attend Exeter NHS Walk in centre or to dial NHS 111 to talk to an Out of Hours service delivered by Devon Doctors.

The following regulated activities are carried out at the practice; Treatment of disease, disorder or injury; Surgical procedures; Family planning; Diagnostic and screening procedures.

We visited the main practice located at: Sedemuda Road, Woolbrook, Sidmouth, EX10 9YA. We did not visit the branch located at Blackmore Drive, Sidmouth EX10 8ET which was being used as a branch surgery.

Detailed findings

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 April 2017.

During our visit we:

- Spoke with a range of staff and spoke with 11 patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.

- Reviewed eight comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

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.

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording spreadsheet did not always contain sufficient detail of recording notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From discussion of the 29 documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. However, records did not always detail the discussions that had taken place, actions taken or demonstrate that events had been reported externally. For example, being reported to the NRLS (The National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports.) There was no written evidence of reporting significant events to external bodies including the CCG.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an answerphone message regarding a test result was not understood by the patient. This resulted in additional training for administration and prescriptions staff. An action included ensuring GPs gave clearer advice to patients regarding test results and a reminder for patients to ring the practice back if they became unwell.
- The practice also monitored trends in significant events and evaluated any action taken. For example, there had

been a trend in issues arising from patients waiting for ambulances later in the day. A protocol had been amended to ensure staff were aware of whose responsibility it was to wait with the patient.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. 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.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. Documents were not readily available to demonstrate GPs had the relevant level of safeguarding children training. However, this was provided shortly after the inspection visit. GPs had received level three child safeguarding training and nurses and health care assistants level two.
- A notice in the treatment rooms advised patients that chaperones were available if required. A chaperone protocol was currently under review and being issued to staff. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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 practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol that had last been reviewed in February 2017 and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any

Are services safe?

improvements identified as a result. For example, the last audit in June 2016 included an audit to ensure all staff had received IPC training. The clinical audit highlighted issues with one sharps bin and a cluttered sink area in a GP room. Both issues were immediately addressed.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

There were processes for handling repeat prescriptions which included the review and monitoring of high risk medicines. The practice used computer software to search for patients taking high risk medicines. All patients on repeat medication have a review by the pharmacist or their GP in their month of birth. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of a clinical pharmacist who was employed one day per week, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and updated systems had been introduced to monitor their distribution and location. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer medicines using patient specific prescriptions.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. Paper recruitment records were efficiently stored and easy to audit and refer to. We found this information had also been stored on a bespoke computer system which was used to monitor recruitment and

employment issues including sickness, performance, staff training and feedback. The system allowed staff to be thanked for outstanding practice and used to connect and communicate with staff.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available, we saw that this had last been reviewed in February 2017, the practice had completed risk assessments to promote the safety of the premises, equipment used, infection control and the occupational health of all staff.
- Records showed fire detection equipment was tested weekly and fire marshals were appointed. We saw an up to date fire risk assessment and a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. The last PAT (Portable appliance test) had been performed in May 2016. The last clinical equipment calibration checks had been performed in October 2016.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Nursing staff were able to perform a number of roles which enabled the right mix of staff to be on duty to meet the needs of the patients

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was 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.

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were 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 stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based guidelines.

- The practice had systems to keep all clinical staff up to date. This included sharing updates at clinical meetings and sending notifications and emails of updates. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Examples seen included lower back pain and sciatica, Sepsis and non-alcoholic related liver disease.
- The practice monitored that these guidelines were followed through audit.

Systems were in place to monitor equipment alerts sent by the Medicines & Healthcare products Regulatory Agency (MRHA). This process was updated on the day of inspection to include medicine alerts.

The management of long term conditions was nurse led at the practice. These patients were called for medicine reviews in the month of their birthday. These patients were issued with written care plans with information also stored within the patient's electronic record.

Management, monitoring and improving outcomes for people

- The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). There were no published QOF results for this new organisation but the practice told us they had already achieved 537.4 of the of the total number of points (545) available at the end of March 2017.

This practice was not an outlier for any QOF (or other national) clinical targets. There was no published data available for this practice.

There was evidence of quality improvement including clinical audit: We looked at five of the clinical audits commenced in the last two years. Three of these were completed audits where the improvements made were implemented and monitored.

Findings were used by the practice to improve services. For example, an audit of guidance given to patients regarding driving with diabetes to ensure that all patients who drive had received and continued to receive advice about avoiding the risk of low blood sugar while driving. The first collection of data showed that of the 431 patients on Insulin or relevant medicine only 21 (5%) had been recorded as having been given appropriate advice. As a result the diabetic team were reminded to record when they had given the patient advice and/or leaflets regarding driving. The second audit showed that of the 286 patients 173 (60%) had been recorded as having received advice and 113 (40%) not recorded as receiving advice. Whilst there had been an improvement, the practice were not happy with this result. Further action taken included the introduction of pop up prompts on the computer to remind staff to record that this information had been given and communication with community nursing staff to clarify the driving status of patients.

The practice were part of a collaborative pharmacist project shared with three other practices. The practice employed a pharmacist one day a week. The pharmacist worked with the GPs, local pharmacies and prescription team to offer advice to patients, conduct medicines reviews, check medicine safety and perform audits of medicines to ensure the correct processes and checks were being followed.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. There was a culture of learning and education within the practice. Nursing staff responsible for the management of long term conditions received

Are services effective?

(for example, treatment is effective)

update training. Many staff had received funding and support to develop within the organisation. For example, healthcare assistants had been trained to assist during operations and perform advanced procedures including stitch removal, ear syringing and injections. Two of the practice nurses were training to become minor injury unit nurses and two nurses were being supported to become nurse practitioners and nurse prescribers.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The 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 their learning needs and to cover the scope of their work. This included ongoing support, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. The appraisal programme was structured and efficiently monitored.
- There were GPs with a special interest (GPwSI) employed at the practice. These included dermatology GPwSI and orthopaedic GPwSI. These GPs performed surgical procedures in the designated operating theatre and offered this service to practice patients and patients from other practices in the area. This approach reduced the need to travel to local hospitals and helped speed up access to dermatology or orthopaedic treatments for a wide range of local people.
- One of the GPs was the lead partner for hospital liaison and is responsible for the implementation and supervision of a foundation 2 doctor, now situated at the Sidmouth hospital.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 investigation and test results. With patient consent, these records were shared with out of hours providers, the ambulance trust and local acute hospital staff. We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital or where they were receiving end of life care. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- 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, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was obtained using templates on the computer system and through written consent for minor surgical procedures.

Supporting patients to live healthier lives

Are services effective?

(for example, treatment is effective)

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition, carers and those requiring advice on their diet, smoking and alcohol cessation.

There was no published data available regarding the practice's uptake for the cervical screening programme. However, the practice said that 81% of eligible patients had received this screening which compared with the CCG average of 81% and national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Published uptake rates for the vaccines given were not available but the practice data showed that vaccines given to under two year olds and five year olds were 90% which met the national target of 90%.

The practice ran flu clinics and had given 4800 Influenza vaccinations in the last year by holding Saturday flu clinics.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer.

Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the eight patient Care Quality Commission 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.

There were no national patient survey results for this newly registered practice. However, the practice had carried out their own in-house survey on over 800 patients. Of the 800 patients 85% said their privacy is respected by the nurse. 8% said it was not applicable and 3% said it was not respected. 72% of patients agreed that when conversations were held with a receptionist their privacy was respected. 11% said it was not respected and 8% said it was not applicable. Comments included that the new building was much better for privacy than the branch surgery. Patients also said receptionists did their best to keep conversations private.

We spoke with 11 patients and one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Patients said they felt involved when planning their care and added that they could challenge and discuss the suggestions and options made by the GPs. Patients said all staff were respectful, friendly and polite.

We did not receive any negative comment about the care and treatment received. One patient said it was sometimes difficult to understand the name from the TV screen announcement so they made sure they were positioned where they could read the screen.

Care planning and involvement in decisions about care and treatment

Patients told us 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 from the eight comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. We spoke with one child who said they liked the toys and the interactive flooring in the waiting room and said the doctor made them better.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We spoke with two patients whose first language was not English. They were aware they could access an interpreter but chose to bring a family member instead.
- Information leaflets were available in easy read format. Staff printed these directly from nationally recognised websites so patients were receiving up to date information.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patient and carer support to cope emotionally with care and treatment

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 323 patients as carers (2.2% of the practice list). There was a carers lead and two health care assistants helped ensure that the various services supporting carers were coordinated and effective. All carers were offered an assessment which

Are services caring?

offered signposting to support groups including dementia care nurse, memory cafes. Information on financial assistance and the Devon carers group was given. Written information was also available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced bereavement, their usual GP contacted them to give advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- There were longer appointments available for patients who needed them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice ran a minor injuries service Monday to Friday. These clinics were overseen by one of the GPs at the practice who had experience of working in emergency departments.
- Patients could receive carpal tunnel surgery and dermatology (for example, suspected skin cancer) surgery at the practice within the designated operating theatre.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- All care homes had a direct line telephone number so that they could contact the practice without delay when needed.
- The practice had responded to feedback from patients and staff regarding access to appointments and had introduced improved call handling, telephone line investment and additional duty GPs on Tuesdays after a bank holiday.
- Patients were able to receive some travel vaccines available on the NHS.
- There were accessible facilities, which included passenger lift (in the new premises) accessible toilets, a hearing loop, and interpretation services.

The Practice worked closely with the Hospiscare nurses to provide responsive end of life care. Staff held quarterly palliative care meetings with the Hospiscare and community nursing teams. The practice minuted these meetings and were considering using the gold standard documents. The GPs also worked closely with the Complex

Care Team with one of the GPs meeting each week with them to discuss patients. The practice had achieved and implemented the Gold Standards Framework for end of life care, had a palliative care register and held regular internal meetings to discuss the care and support needs of patients and their families.

Access to the service

The main practice, Beacon Medical centre, was open from Monday to Friday, between the hours of 8am and 6pm; appointments were available during these times and phone calls were diverted to the out of hours provider after hours. The branch practice, Blackmore Health Centre, was open every Monday, Wednesday, Thursday and Friday, between the hours of 8.30am until 1pm and then 2pm until 5pm and every Tuesday and between 8.30am and 1pm. Patients could book routine appointments up to eight weeks in advance. If a patient was not able to get a routine appointment with their own GP within 3 weeks then they were offered an alternative GP if they wish. Urgent appointments were also available for patients that needed them.

There were no national patient survey results for this practice. However, the practice had conducted their own in house survey in April 2016 using an online questionnaire. There were over 800 responses which showed 81% of patients were able to receive a telephone call from the GP when needed and 81% of respondents were happy with opening times. However, patients had not been happy about the length of time it took to get an appointment with their named GP. For example, just 39% of patients said it was easy to get a timely appointment with a GP and 48% of respondents said it was easy to get a timely appointment for routine matters. The practice manager had shared these findings with the Patient Participation Group (PPG) who had monitored the actions taken by the practice and the amount of appointments available for patients. Actions taken included investment of the telephone line, employing additional staff and changing the appointment process to ensure patients could book an appointment with another GP if they could not see their own GP within three weeks.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. Patients said if they needed to see a GP about an acute problem

Are services responsive to people's needs?

(for example, to feedback?)

they were seen either on the same day or the next day. However, they added for more routine matters they sometimes had to wait a little longer to see the GP of their choice.

The practice had a system to assess:

- Patients who needed to be seen by the duty GP. A duty personal assistant was employed to help with the administration of these appointments and contact patients where appropriate. A second duty GP was employed on anticipated busy days.
- To ascertain whether a home visit was clinically necessary; there was a triage system used for this purpose and an allocation protocol so clinicians were clear of who would be visiting the patient

The practice had a minor injury unit which was started in the summer of 2016 and was open during the practice opening times on weekdays. This was managed by the nurse practitioner and practice nurses.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. However, not all patients we spoke with were aware of how to make a complaint, although none of the eleven patients we spoke with had encountered a reason to complain. These findings aligned with the in house patient survey. For example, only 53% of the 800 respondents were aware of how to complain.

There was a link on the website for patients to complain. Information on how to complain was included within the patient leaflet and displayed on the TV screens in the waiting areas. Leaflets were available on the desk in the waiting areas.

We looked at the 30 verbal and formal complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely open and transparent way. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a patient had been unhappy with a change of medicine which they had not been informed of. The patient was given an apology and the member of staff who had changed the prescription was reminded to contact the patient when medicines were changed.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored at the weekly business meetings, monthly partner meetings and annual strategy away days.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. However, staff added that there was a sense of team work and cross cover meant that the responsibility for roles was shared. GPs and nurses had lead roles in key areas. Each GP partner had an area of responsibility and chairs for meetings were rotated to ensure the role was shared. There were systems in place to cover staff absences to ensure test results and issues were addressed on the same day.
- A structured programme of meetings was in place. Partners met daily for coffee and all staff were able to come along to speak with the GPs. GPs also met weekly to discuss business issues. These were held on different days of the week to enable all partners to attend in working time. Management team meetings were held twice a week and partners also held a monthly evening partners meeting where all partners could attend. The practice closed four times a year so staff could attend training and learn about the performance of the practice. An annual strategy away day was held where key members of staff were invited to participate where appropriate. The practice also held social events and team building events.

- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. These included minor surgery, infection control, environmental, medicines management and clinical audits.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Environmental safety checks were managed efficiently using a rolling programme of checks.
- Systems were in place to monitor equipment alerts sent by the Medicines & Healthcare products Regulatory Agency (MRHA). This process was updated on the day of inspection to include medicine alerts.
- Practice specific policies were implemented and were available to all staff. The majority of these had been updated and reviewed. Nursing staff had their own policy file in place for clinical policies. The human resources computer system was used to update and review policies / protocols. Once a policy has been reviewed, policies are sent out via the HR People system requesting an electronic signature from all staff confirming they have read and understood the updated document.

We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. However, records of these meetings did not always reflect the level of detail known by staff who attended the meetings.

We found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. However, records did not always detail the actions taken or demonstrate that events had been reported externally. For example, being reported to the NRLS (The National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports). This was amended on the day of inspection. Additionally there was no written evidence of reporting significant events to external bodies including the CCG.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and

Are services well-led?

Good 

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

capability to run the practice and ensure high quality care. Staff explained that the leadership at the practice was good and each member of staff had a line manager to report to. Staff told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff. The human resources computer system was used to communicate thanks to staff, wish them a happy birthday and highlight where training had been achieved. Staff said the practice was a good place to work and that staff turnover was low.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. We found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses, palliative care staff and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, and had been regularly meeting with the practice manager to review GP appointments which was a standing agenda item on the minutes.
- The NHS Friends and Family test, complaints and compliments received. Of the 76 results received since April 2015, 63 people said they would be extremely likely or likely to recommend the practice
- Staff through an annual staff survey and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There had been a recent staff survey. Findings had been positive. 29 staff had returned the survey which showed that all thought the roles and expectations they had were realistic. 26 of the 29 were satisfied in their job and all 29 were proud to work at the practice.

Continuous improvement

There was a 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.

The practice was a teaching and training practice. GPs worked with the university of Exeter Medical School and provided support for 4th and 5th year medical students. One of the GPs provided support and training for FY2 doctors (A Foundation doctor (FY1 or FY2 also known as a house officer) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.) who are working at the local community hospital.