Mayfield 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 inspection at Mayfield Medical Centre on Wednesday 24 June 2015. The practice is rated as good. It was good for providing safe, effective, caring, responsive and well led services. It was good for providing services for all the population groups, older people, families, children and young people, people with long term conditions, people in vulnerable circumstances, people experiencing poor mental health and people who are working age or recently retired.

Our key findings were as follows:

- Outcomes for patients were positive, consistent and met expectations. Patients told they could get an appointment with their own GP or a GP of their choice, which provided continuity of care. They confirmed they were seen or spoken with on the same day if they had an urgent need. GPs kept individual lists so all patients had a named GP.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Reliable systems were in place to maintain safety throughout the practice. There was a health and safety manager in a dedicated health and safety role.
- There was good IT support to enable staff to manage patient records well.
- Treatment rooms and public areas were clean and there were systems in place to ensure hygienic conditions and equipment.
- The practice implemented suggestions for improvements and made changes to the way it

delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

- 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.

Summary of findings

We found one area where the practice needs to make improvements. Importantly, the provider should:

Improve patients' privacy and maintain their dignity during examinations, investigations and treatments in rooms without screens or curtains.

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. This practice was safe and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Equipment was checked and tested as required. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data showed the practice had systems in place to make sure the practice was effectively run.

The practice had a clinical audit system in place and audit cycles had been completed. Care and treatment was delivered in line with national current practice guidance. The practice worked closely with other services and strived to achieve the best outcome for patients.

Supporting data showed staff employed at the practice had received appropriate support; training and appraisals had been undertaken for all clinical staff. GP partner appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information

was provided to help patients understand the care available to them. Staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The needs of the local population were reviewed and the practice engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make

Summary of findings

an appointment with a named GP and that there was continuity of care. This was confirmed by the latest GP patient survey which showed that patients were able to get an appointment to see or speak to someone the last time they tried. The practice provided a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

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.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the vision of the organisation and their responsibilities in relation to this. The strategy to deliver the vision was regularly reviewed and discussed with staff. There was a leadership structure in place. The practice manager played a central role in the coordination and running of the practice.

Staff felt supported by management. There was a stable staff group and high level of job satisfaction and support for nursing and clerical staff. The practice had a number of systems, policies and procedures to monitor risk, clinical effectiveness and governance and to share learning from any events. The practice valued and proactively sought feedback from patients and staff and this had been acted upon. The practice had an active patient participation group (PPG). The PPG were proactive in improving services for patients and influenced changes at the practice. Staff had received inductions and had attended staff meetings and events.

Staff said they felt well supported and enjoyed their work. They said communication was good amongst each other. There was a stable staff group with most staff having worked at the practice for many years.

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 the practice had better than average outcomes for conditions commonly found amongst older people. The practice had a register of all patients over the age of 75 and these patients had a named GP. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in relation to caring for patients with dementia, shingles vaccinations program and end of life care.

The care for patients at the end of life was in line with the gold standard framework. This meant they worked as part of a multidisciplinary team and with out of hour's providers to ensure consistency of care and a shared understanding of the patient's wishes.

The practice was responsive to the needs of older people, GPs, nurses and health care assistants provided home visits and rapid access appointments for those with enhanced needs. We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over who were vulnerable had care plans in place.

Patients who lived in nursing homes had twice yearly reviews of their care undertaken by their GP visiting them at the home.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

The practice had clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encourage self-care for these patients.

There were weekly clinics to treat and support patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

Yearly home visits and medication reviews were arranged for housebound patients with long term conditions.

Summary of findings

The practice worked closely with the community matrons for patients who had acute conditions to prevent hospital admissions. Patients who were on the unplanned admissions register were contacted following being discharged from hospital to identify any changes to care and treatment required and reviews of care were discussed at practice meetings.

Clear alerts were placed on the appointment system highlighting vulnerable patients to ensure reception staff acted in a timely manner and allocated same day appointments or home visits. A recall system was in place for patients with chronic diseases.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up vulnerable families who were at risk.

Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals, we saw evidence to confirm this. We saw that staff dealing with young

patients under 16 years of age without a parent present were clear of their responsibilities to assess Gillick competency. Sexual health, contraception advice and treatment were available to young people including chlamydia screening.

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. Immunisation rates were high for all standard childhood immunisations.

All of the staff were very responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Staff were knowledgeable about child protection and proactive in raising concerns with the safeguarding lead to follow up on any identified. One GP had the lead role for safeguarding within the practice; they worked with the local authority and other professionals to safeguard children and families.

Working age people (including those recently retired and students)

Good

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

Summary of findings

The staff were proactive in calling patients into the practice for health checks. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. The practice also offered age appropriate screening tests including prostate and cholesterol testing.

Patients who received repeat medications were able to collect their prescription at a place of their choice. The staff often posted the prescription to a pharmacy of the patient's choice, which may be convenient to their work place.

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 those with learning disabilities. The practice had offered annual health checks for people with learning disabilities and 100% of these patients had been offered one. Those that declined were offered again. The practice offered longer appointments for people with learning disabilities and recognised their individual needs. For example, they used the same members of practice staff and visited the patient at home if that avoided distress to the patient.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 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). All people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and in house wellbeing services were provided on site. The practice had a system in place to follow

Summary of findings

up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

On the day of our inspection we reviewed 21 comment cards, which had been completed in a two week period before the inspection date. All of the comments we received were positive about the experience of being a patient registered at the practice. There was a recurrent theme of patients saying that they were treated with support and care.

We also spoke with six patients and their views aligned with the comments in the cards we received. Patients gave us positive examples of treatment they received and support offered by practice staff. All said they were treated with dignity, respect and kindness by staff. Results from the most recent GP national patient survey in April 2014 – March 2015 stated that 93% of 128 patients rated their overall experience of the practice as at least good or fairly good.

Areas for improvement

Action the service SHOULD take to improve

We found one area where the practice needs to make improvements. Importantly, the provider should:

Improve patients' privacy and maintain their dignity during examinations, investigations and treatments in rooms without screens or curtains.

Mayfield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. It included a GP specialist adviser, and a practice nurse specialist adviser.

Background to Mayfield Medical Centre

Mayfield Medical Centre was inspected on 24 June 2015. This was a comprehensive inspection.

The practice is situated in the town centre of Paignton. The practice provides a primary medical service to approximately 13,900 patients and is a training practice for qualified doctors who are training to become GPs.

There is a team of six GP partners and four salaried GPs with a whole time equivalent of 8.63 due to some full time and some part time working (five female and five male). Partners held managerial and financial responsibility for running the business. The team were supported by a practice manager, deputy practice manager, accountant business manager, health and safety manager, two female nurse practitioners, four female practice nurses, two female health care assistants and one phlebotomist. The clinical team were supported by additional reception, secretarial and 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.

Appointments are available 8am to 6pm Monday to Friday. There were no extended hours offered. Data from the 2014-15 GP Patient Survey patient showed that 81% of 128 patients who responded were happy with the practice's opening hours. This was higher than the national average of 76%.

The practice has an established patient representation group (PPG). This is a group that acts as a voice for patients at the practice.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hour's service.

Mayfield Medical Practice had a branch practice at Cherrybrook Medical Centre, Hookhills Road, Paignton TQ4 7SH. We visited Mayfield Medical Practice as part of our inspection; we did not visit the branch practice.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 24 June 2015.

During our visit we spoke with a range of staff including four GPs, two practice nurses, a nurse practitioner, the practice manager and members of reception and clerical staff. We spoke with six patients who used the service. We reviewed 21 CQC comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts. The practice had a health and safety manager. The number of incidents reported in the last 12 months was low (three) but where they had occurred, investigations, outcomes and actions were clearly documented. The staff we spoke with were aware of their responsibilities to raise concerns and were able to describe the procedure for reporting incidents and near misses. Staff were able to describe a recent incident where a patient had become confused over a medicine dosage. We saw an investigation had taken place and actions plans put in place. For example, the practice provided the patient with a written printout showing the correct dosage, in addition to the dosage sticker displayed on their medicine.

Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe. We reviewed minutes of meetings where incidents and complaints were discussed during the last 12 months and reviewed incident reports which had been collated for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events and incidents were reported on a standardised form which included a description of the incident, what went well in handling the incident, what could have been done

differently and what could be learned from the incident to prevent a reoccurrence.

Staff including receptionists and administrators were aware of the process to follow and send completed incident forms via email to the management team. There were three records of significant events that had occurred during the last year and we were able to review these.

One significant event included an incident where the GP told the patient that they would be contacted within two days regarding an appointment. A misunderstanding had arisen between the GP, the patient and the receptionist as to the next step to take. As a result the patient had not booked an appointment. Shared learning had been taken forward from this event.

National patient safety alerts were disseminated by email and at the clinical meetings to staff. There was a lead GP for this. We saw a recent alert regarding Middle East Respiratory Syndrome (MERS) had been disseminated appropriately on 17 June 2015. Staff we spoke with told us that they had received information about alerts and they were discussed as and when necessary.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were safeguarding policies in place for both children and vulnerable adults which included contact details for local safeguarding and social care teams. Flowcharts detailing the procedure for escalating safeguarding concerns were posted in consultation rooms for quick reference to ensure staff reported any concerns promptly.

We saw training records which showed that all staff had received relevant role specific training in child protection. All administrative staff were trained to level one and all clinical staff were trained to level three in accordance with national guidance. Staff had also received training in the protection of vulnerable adults. The practice had appointed a dedicated GP who had a lead role in safeguarding vulnerable adults and children. They had been trained in safeguarding adults and also level three child protection to enable them to fulfil this role. All staff we spoke to were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern. We asked administrative staff about their most recent training. Staff we spoke with were able to describe signs of abuse in older people, vulnerable adults and children. One staff member was able to provide an example of a safeguarding concern that she escalated to the practice safeguarding lead. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

Good

Are services safe?

There was a red alert message system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The practice had a chaperone policy and signs were visible on the reception desk notice board and in the consultation rooms offering the chaperone service. We were told that clinical staff usually carried out chaperone duties. Clinical staff and administration staff had received chaperone training. All staff at the practice had received a Disclosure Barring Service (DBS) check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The temperatures were checked and documented once a day and we saw an appropriate temperature range had been maintained. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a breach of these temperatures. The practice had a spare refrigerator available for contingencies.

The practice nurses were responsible for ensuring medicines were in stock and within their expiry dates. Vaccines were checked weekly for their expiry dates and rotated so that vaccines closest to their expiration date would be used first. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and changes to

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

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We reviewed cleaning schedules and records detailing the frequency and areas of cleaning undertaken. These schedules were detailed on an individual room basis and took into account the purpose of how each room was used. All of the patients we spoke with said they always found the practice to be clean and tidy and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits in the last year and that any improvements identified for action were completed on time. For example, the infection control audit had identified that privacy curtains around patient couches in treatment rooms needed to be vacuumed weekly as part of the general cleaning schedule and taken down and cleaned at 60 degrees at least six monthly and immediately when soiled (unless disposable curtains were used).

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the practice had a clinical waste management protocol in place and waste was segregated, stored safely and

disposed of by a professional waste company. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff informed us that all PPE and probes used in examinations were single use to minimise cross-infection risks.

The practice had a contract with an external agency for daily safe removal and disposal of sharps waste.

The practice had a risk assessment in place for legionella (a germ found in the environment which can contaminate water systems in buildings). Checks were carried out on a weekly basis.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

Good

Are services safe?

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly for patient use and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date in October 2014. A schedule of testing was in place. Calibration of medical equipment was undertaken by an external contractor annually.

Staffing and recruitment

Records showed that there was a low turnover of staff at the practice. We looked at three staff records, all of which contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring

Service (DBS). All of the records contained photographic identification. Management told us that all staff at the practice had received a DBS check. This followed practice policy.

Original checks had been completed, which showed that the performers list had been checked when GPs and locums were recruited. Copies of medical defence insurance were seen in files, which were valid for the current year. The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed meet patients' needs. Nurses had completed several advanced nursing diplomas. These included the respiratory care of patients, diabetes management, contraception, sexual health promotion and mental health issues.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice was recruiting for a practice nurse to provide maternity cover for three days a week during our inspection.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and a health and safety manager with a dedicated role for this area. Health and safety information was displayed for staff to see. We saw evidence of health and safety risk assessments where identified. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. For example, in fire safety, there was a box of children's toys that had been stored in front of a fire exit. As a result of the fire risk assessment, the box and the children's area had been relocated away from the fire exit.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in February 2015. Further training was planned for November 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED – a device used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. A nurse checked the resuscitation equipment weekly. All equipment and adrenaline were in date and recorded on a chart. Equipment was available to help adults and children who were having difficulty breathing.

Every staff member with access to a computer screen could request immediate assistance. This function was used if a patient collapsed or who otherwise became acutely unwell. By requesting immediate assistance an alert went to all active users on the computer system.

Risks to safety from service developments, anticipated changes in demand and disruption were being assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations. A business continuity plan was in place and had been reviewed in July 2013. This covered the range of anticipated emergencies, assessed their potential impact and assigned responsibility to staff for alerting others and preventing escalation. This covered breakdown of systems including computers, adverse weather including flooding.

Good

Are services safe?

Arrangements were in place to arrival of an infected or contaminated patient as well as a strategy to act in the event of a pandemic perhaps in collaboration with other neighbouring practices and/or the CCG and Public Health England. Clear instructions for staff had been prepared and useful contact details listed.

The practice had a fire safety policy, a fire safety log book and a fire safety risk assessment which had been completed in February 2015 by the practice Health and Safety manager. Fire alarm checks were undertaken weekly and fire drills had been practiced regularly to ensure patients and staff could be evacuated in the event of a fire. The local fire service had visited the practice and completed a fire risk assessment in April 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they led in specialist areas such as child, teenage and women's health and care for the elderly. The practice nurses led clinics for specific conditions such as asthma, chronic obstructive pulmonary disorder and diabetes which allowed the GPs to focus on patients within their specialist areas. Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance. We saw practice performance data for effective treatment of patients which was in line with the local CCG targets. For example, the number of patients on the heart failure register (69) had all been invited in for an annual review and 100% of these patients had attended this practice and completed their review.

Other examples included the 308 registered patients with respiratory conditions requiring spirometry testing. The CCG target was for 80% of these patients to receive an annual review. The practice had achieved 91%. Of the 434 patients diagnosed with cancer, 93% had been reviewed by a GP within three months of diagnosis. This was higher than the CCG target of 90%.

The practice used computerised tools for information regarding patients who had experienced an unplanned admission to hospital and this would be forwarded by the administration team to the patient's named GP.

The practice referred patients to secondary care and other community care services appropriately. Data showed that the practice was performing in line with CCG standards on referral rates for all conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. Patients we spoke to told us that they felt listened to in decision-making about their care.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. The practice managed the care of patients over the age of 75, patients with mental health conditions and patients receiving integrated and palliative care by allocating them a named GP.

Key roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us seven clinical audits that had been undertaken in the past year. We saw that the practice had completed three cycles of warfarin audits (a medicine used to stop blood clots) and appropriate actions had been taken to adjust patient's dosages following the audits.

A BNP audit (a substance secreted from the ventricles or lower chambers of the heart in response to changes in pressure that occur when heart failure develops and worsens. The level of BNP in the blood increases when heart failure symptoms worsen, and decreases when the heart failure condition is stable) had identified whether regular blood tests had been completed and whether secondary care had followed up any actions. Shared learning had taken place following this audit.

A salbutamol audit (salbutamol is used in the treatment of asthma) had identified whether patients were receiving the correct dosage and in some cases inhaler usage had been reviewed.

All of these audits had dates factored in to repeat the process and complete a full cycle. The practice showed us an example where a change had occurred resulting from an audit. We saw that audits had been undertaken to ensure that the current practice used was compliant with NICE guidance.

The practice also 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 voluntary system for the

Good

Are services effective?

(for example, treatment is effective)

performance management and payment of general practitioners. For example, 90% of 89 patients with dementia had an annual face to face review. This was higher than the QOF target was 80%.

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

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

Effective staffing

The practice had an experienced team of staff that included medical, nursing, managerial and administrative staff. We saw staff turnover had been very low. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The practice held long well established links with local medical schools and had provided training for student doctors and doctors continuing in their education. Two fourth year medical students (training to become doctors) were placed at the practice for three one week visits per year. This had taken place over the last five years.

A supportive and positive culture within staff was evident throughout our inspection. All clinical staff undertook annual appraisals which identified learning needs and the practice was proactive in providing training in the areas identified. Nursing staff at the practice had defined duties and were able to demonstrate they were trained to fulfil these duties. For example, undertaking of spirometry and wound care. Those with extended roles for example triage had extended training in physical assessment. Two staff had completed a diabetic degree module; two staff had completed a degree module in asthma. All nurses had completed a spirometry course and had their work audited by respiratory specialist nurses at the local hospital. One member of staff had completed additional training in COPD (chronic obstructive pulmonary disease).

Working with colleagues and other services

The practice had effective working arrangements with a range of other services such as the local authority, the hospital consultants and a range of local and voluntary groups. A heart specialist from the local hospital had visited the practice and delivered a presentation to all staff in April 2015.

The practice was involved in various multidisciplinary meetings involving palliative care nurses, health visitors, social workers and district nurses to discuss vulnerable patients at risk, those with complex health needs, and how to reduce the number of patients needing hospital admission. The lead GP for safeguarding children attended monthly multidisciplinary meetings with school nurses, health visitors and midwives to discuss patients on the child protection register and other vulnerable children. This enabled the practice to have a multidisciplinary approach which ensured each patient received the appropriate level of care.

The practice worked with other service providers to meet patients' needs and manage complex cases. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

Good

Are services effective?

(for example, treatment is effective)

a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Devon single point of access scheme. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Regular meetings were held throughout the practice. These included all-staff meetings, clinical meetings, business meetings and partner meetings. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and the Children's and Families Act 2014 and their duties in fulfilling it. Formal training in the Mental Capacity Act 2005 had been undertaken by GPs, nurses and senior administrative staff. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example, we saw evidence that a GP had been involved in a Best Interests meeting with a patient who lacked the capacity. GPs demonstrated an understanding of both Gillick and Fraser guidelines (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). Patients with a learning disability and those with dementia were supported to make treatment decisions through the use of care plans, which they were involved in agreeing.

Health promotion and prevention

The practice had met with the public health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion

activity. It was practice policy to offer all new patients registering with the practice a health check with a GP.

We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 years and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability (32) and all had been offered an annual physical health check. Practice records

showed 100% had been offered checks and of these 66% had received a check up in the last 12 months. Patients who did not undertake a health check were provided with a reminder.

The practice had access to a smoking cessation support service to assist the 2936 patients who were recorded as smokers. 64% of these had been referred to the smoking support service with their consent. The remaining 36% had declined the offer. It was not known how many of the 64% had successfully stopped smoking since being referred to the service.

The practice's performance for cervical smear uptake was 79%, which was in the upper bracket of the CCG target of 45-80%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all child immunisations was 97% which was in line with, or above average for the CCG. There was a clear policy for following up non-attenders by the practice nurses.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from information from the national GP patient survey 2015. We spoke to six patients during our inspection and we received 21 Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed a high level of satisfaction of patients with their

GP practice. The results of the practice patient satisfaction survey showed that of the 128 responses received, 93% of patients described their overall experience at this practice as good, which was higher than the CCG average of 90% and national average of 85%. We received 21 comment cards and all of these stated that the service was good, very good or excellent.

The practice offered a transport scheme run by a voluntary group with their own cars for those people who did not have the ability or means to use public transport. It enabled vulnerable patients to visit the practice for their appointments.

Patients said the nurses and GPs were very caring and they had received an excellent service. One patient said they had received first class treatment at all times including when they were really unwell and needed advice and an emergency appointment. Patients said their GP always

listened to what they had to say. Patients said their GP had given very good in-depth

explanations when they needed further treatment. Others said the GP got the right information for them, listened to them and their questions had been answered.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. However, we found that not all of the treatment rooms had curtains. Staff told us that they waited outside a room without a curtain whilst the patient got changed. The management informed us that a curtain would be replaced immediately.

We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Patients said they felt the practice offered a good service and both

clinical and administrative staff were helpful and caring. They said staff treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient

survey showed 90% of 128 practice respondents said the last GP they saw or spoke to was good at involving them in care decisions. This was higher than the CCG average. Patients we spoke with on the day of our inspection 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

GPs and nurses were able to demonstrate an understanding of Gillick guidelines used to help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge.

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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93% of 128 patients surveyed considered they were treated with care and concern during their

Good

Are services caring?

consultation with the clinical team, which was higher than the 91% CCG average. The six patients we spoke with on the day of our inspection and 21 comment cards we received were also consistent with this survey information.

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. Appointments were available for carers to have a health check if required.

We spoke with the carer support worker employed by the practice. They supported carers with health checks and carers assessments which offered emotional support schemes. They were able to signpost carers to apply for one off carer's direct payments and could refer them to the local social care team for occupational health assessments at home. They provided carer's with details of respite care and other support agencies. Information about this service was displayed in leaflets, on the noticeboards and on the practice website.

In the event of bereavement the practice sent out a sympathy card to the family concerned. We saw an example of this card which contained the contact details of local bereavement support and counselling services.

A congratulations card was sent out to patients after the arrival of a new baby. This card also contained the details of relevant support services such as child vaccinations and dates and times of the baby and child clinic at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We saw evidence that the practice management team involved the patient participation group (PPG) in the

development of their patient survey and action plans in response to the feedback received. For example, the practice had provided higher chairs with arm rests with varying heights, a door had been widened in line with the Disability Discrimination Act 2005, a water cooler had been provided in the waiting room and the website had been updated to include information about voluntary groups and support services.

Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. The GPs had individual lists, to promote continuity, and attached staff paid tribute to the focus on continuity of care within this practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. Temporary residents were welcomed.

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

The practice had level access to the front door. The disabled toilet facilities were on the ground floor. Some GP consultation rooms and the treatment rooms were on the ground floor and first floors, there were two stair lifts, one of each of the two staircases. We spoke with a member of staff with mobility issues during our inspection who told us they did not it difficult to get around the building.

The seats in the waiting area were of different heights and size. There was variation for diversity in physical health and all had arms on them to aid sitting or rising. A hearing aid induction audio loop was available for patients who were hard of hearing. There was an area for children to wait which had toys and books for them to read and use.

Access to the service

Appointments are available 8 am to 6 pm Monday to Friday. There were no extended hours offered. Data from the last GP Patient Survey patient showed that 81% of 128 patients who responded were happy with the surgery's opening hours, compared to the local (CCG) average of 80% and a national average of 76%.

A GP operated as duty doctor with the administration staff taking telephone appointment calls and could discuss needs with the patients and determine if an urgent appointment was required. They were also supported by an assisting GP. Over 70% of appointments were available the same day and 30% were pre bookable.

The practice varied the amount of appointments available depending on demand. Patients were able to book routine appointments up to four weeks in advance with a preferred GP. Extra appointments were also released on a daily basis. All of the patients we spoke with on the day of inspection confirmed that they had been able to make an appointment with their preferred GP. One patient told us they sometimes had to wait up to two weeks to see their preferred GP.

The data we reviewed from the GP Patient Survey showed the practice had performed above the local and national averages in patient satisfaction with appointments. For example, 97% of 128 patients who responded to the survey said they were able to get an appointment to see or speak to someone the last time they tried.

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 managed all

non-clinical complaints and the clinical lead managed all clinical complaints in the practice.

We saw that the complaints procedure was displayed on posters in the reception area and there was a complaints leaflet to help patients understand the complaints system.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a complaints policy and maintained a complaints log. We looked at the complaints log for the last 12 months which recorded complaints received verbally, via email and in writing. We reviewed 24 complaints received in the past year and found that these had been satisfactorily handled.

At the time of our inspection the practice had no outstanding complaints being dealt with and there were no serious clinical complaints received in the last 12 months.

The practice reviewed complaints to detect themes or trends. Lessons learned and actions taken in response to the complaints received were discussed and shared with staff.

The practice had a positive approach to complaint handling. One complainant had been so satisfied with the outcome of their complaint resolution that they had elected to join the patient participation group.

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

There were clear vision and values, driven by quality and safety, which reflected compassion, dignity, respect and equality. The practice had a mission statement. This was to provide consistently high quality medical services and offer a variety of additional services.

Linked to this mission statement, the practice had what they called "a five star plan for a five star service". These five points were

1. providing a sensitive, personal, primary and continuing medical care
2. intervene educationally and preventatively to promote health
3. seek enable people to choose their healthcare from a wide range of options
4. provide a supportive environment, which encourages everyone to work as a team and achieve standards of personal excellence
5. manage all the available resources in the most professional and efficient way

Staff knew and understood the mission statement and the five points. From a patient point of view the practice was working well and in keeping with their mission statement. GPs told us they consulted with all employed and attached staff including health visitors, midwives, community nurses and the patient participation group (PPG).

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The policies were reviewed annually and the network shared policies to ensure best practice. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GP leads for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. Staff we spoke to told us that QOF dashboard data was regularly discussed each month at clinical meetings and development plans were produced to improve targets. The practice also held an annual clinical meeting to discuss QOF and plan activities for the forthcoming year.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

The practice had a programme for practice team meetings. All practice meetings were minuted, emailed to staff and stored on the computer hard drive. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We reviewed a number of policies and procedures, for example recruitment, induction and staff appraisal which were in place to support staff. There was a staff handbook which was provided to all staff. Staff we spoke with knew where to find these policies if required, on a computer based document library.

The practice also had a whistleblowing policy which was available to all staff electronically on any computer within the practice which had been reviewed in October 2014. Staff were aware of the whistleblowing policy if they wished to raise any concerns.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the GP patient survey which showed patients were satisfied with the care they received. For example, 93% said the last GP they saw or spoke to was good at treating them with care and concern this was higher than the local CCG average of 91%.

We spoke with a member of the practice patient participation group (PPG). The current PPG had been formed from a merger of two PPGs since the 2014 merger of Mayfield Medical Centre with Cherrybrook Medical Centre. The PPG currently had 50 members. The group met up on a

Are services well-led?

Good

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

quarterly basis. The practice had acted upon feedback from the PPG including the provision of new furniture for the waiting room and also the provision of oxygen saturation devices in order to measure blood oxygen levels.

The practice also had a patient and carer support voluntary group called 'Cherryaid' since 1998 with 20 volunteers. This group provided transport services to and from the practice for patients. The group held coffee mornings, book sales, organised coach trips and flower arranging events to raise funds. The group was self-funding and had bought a spirometer for the practice, refurbished a treatment room, obtained a children's bead play table and magazine racks. We spoke with members of the PPG and Cherryaid during our inspection and feedback about the practice was very positive. The practice had supported these groups with facilities for meetings and events.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, the practice had completed an employee engagement questionnaire in May 2015. 14 questionnaires had been sent out and eight returned. We looked at analysis of these questionnaires. Staff stated they felt their opinions counted, they received praise and recognition and that they had opportunities to learn and grow.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice allocated protected time for discussions on referrals, results and prescribing and provided an opportunity for personal development and career progression.

We looked at three staff records including a GP, nurse and receptionist. We saw that regular appraisals took place for the clinical staff which identified areas for development with timescales for achieving these. Administrative staff had also had regular appraisals.

The practice closed two afternoons per year in response to a CCG incentive. This was allocated training time for all staff. The time was used for group training sessions and sometimes an outside trainer attended. The most recent training had been a question and answer session with all GPs and staff present, in line with staff requests. This helped to strengthen consistency at the practice.

There was a strong focus on continuous learning and improvement at all levels of the organisation. The NMC charges for medical indemnity were refunded to the nurses as good practice. Nurses told us they were pleased with their support and proud of the quality of the practice. The practice was a training practice for medical students training to become GPs. Experienced and qualified practice GPs were responsible for mentoring the medical students.