Devon Square Surgery

Quality Report

44 Devon Square
Newton Abbot
Devon
TQ12 2HH

Tel: 01626 332182
Website: www.devonsquare.co.uk

Date of inspection visit: 10 July 2014
Date of publication: 25/11/2014

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.

Contents

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

Devon Square surgery was inspected on Thursday 10 July 2014. This was a comprehensive inspection.

Devon Square Surgery provides primary medical services to patients living in Newton Abbot and the surrounding areas. The practice is in Newton Abbot. At the time of our inspection there were 8,520 patients registered at the practice.

There was a team of seven GPs meeting patients' needs. Five GPs were partners, meaning they held managerial and financial responsibility for running the practice. In addition there were three registered nurses, and three health care assistants.

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

Our key findings were as follows:

Patients spoke very positively about the staff employed at the practice and the level of care they received. Patients told us they felt that the practice is safe. They told us that care was given to them in accordance with their wishes and opportunities were given for informed decision making. Patients told us they felt the practice was responsive to their needs. For example, patients said that an urgent appointment could always be obtained on the day they contacted the practice and they could usually see their named GP for non-urgent visits or speak to a GP by telephone. This was reflective of the information provided on the practice website and within the practice welcome pack.

Patients told us about their experiences of the practice. Responses from 10 patients we spoke to on the day, from the two comment cards left for us and within the practice's own patient survey involving 101 patients in February 2014, were very positive. Views of external stakeholders were very positive and aligned with our findings.

There was evidence that learning from incidents, significant events and investigations took place and appropriate changes are implemented to improve the practice and patient experiences.

The practice was managed well, with a clear leadership structure in operation. The staff we spoke with spoke positively about the management within the practice and told us they felt supported in their roles. Supporting information reviewed during our inspection demonstrated the practice had appropriate systems in place that regularly monitored the safety and effectiveness of the care provided.

Recruitment, pre-employment checks, induction and appraisal processes were robust. Staff had received training appropriate to their roles and further training needs had been identified and planned.

Documentation about the practice demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

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

The provider should:

- Consider storing records of the audits centrally to provide a resource for students, trainees and staff at the practice.

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 service was safe. Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

The practice had systems to help ensure patient safety and responded to emergencies well.

Recruitment procedures and checks were completed as required to ensure that staff are suitable and competent.

There was a system in operation which encouraged and supported staff to learn from any significant events or incidents.

There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were suitable arrangements for the efficient management of medicines.

There were environmental risk assessments showing potential risks to the health, safety and welfare of the patients, staff and visitors were in place.

The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard. There were effective systems in place for the retention and disposal of clinical waste.

Are services effective?

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

The provider had a clinical audit system in process and audits had been completed. Care and treatment was delivered in line with national best practice guidance. However, electronic records were not well organised and so finding relevant information pertaining to the effectiveness of auditing processes was problematic.

The provider worked closely with other services to achieve the best outcome for patients who used the practice.

Staff employed at the practice had received appropriate training, support and appraisal. GP partner's appraisals had been completed annually.

We saw that the practice had extensive health promotion material available within the practice and on the practice website.

Summary of findings

Are services caring?

The service was caring. We spoke with patients who spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them, either about their physical, mental and emotional health, health education and what was happening at the practice. Patients told us they are included in the decision making process about their care.

Patients told us they felt they had sufficient time to speak with their GP or a nurse. They said they felt supported both during and after consultations, or through any subsequent diagnosis and treatment.

Are services responsive to people's needs?

The service met patient's needs. Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

There was a clear complaints policy available within the practice and on the practice's website. The practice had responded appropriately and in a timely way to any complaints received. Patients we spoke to said they had had no reason to complain. This was also reflected in the comment card responses we received.

The practice actively sought patient's views and gathered this information by patient satisfaction questionnaires. Patient surveys were carried out in November 2012 and 122 patients completed the practice's questionnaire. The survey was repeated in February 2014, where 101 patients commented about the practice. We saw the practice acted upon comments made by patients in order to improve services for them. The practice had responded well to recent feedback from patients about the appointment and prescription systems.

Are services well-led?

We found the service was well led. There was a clear leadership structure in operation. Staff demonstrated they were clear about their responsibilities and how and to whom they should escalate any concerns.

Staff spoke positively about their employment at the practice. They told us they are actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

Summary of findings

There was a clinical auditing system in operation with clinical risk management tools used to minimise any risks to patients, staff and visitors. There was an eagerness to improve documentary evidence of the governance system to make accessing electronic information easier within the practice.

The practice recognised the importance of patient feedback and ensured that appropriate facilities are available and advertised for patients to see. The practice patient participation group (PPG) are involved in carrying out patient feedback questionnaires. The last of which had resulted in a change and on-going monitoring of the appointment and prescription system.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection and one representative of patients registered with the practice who were living in a nearby care home. We also spoke with a representative from the virtual patient participation group (PPG).

The practice had provided patients with information about the regulatory function of the Care Quality Commission prior to the inspection and displayed our poster in the waiting room. Our comment box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected two comment cards. Both of these comment cards contained detailed positive comments about the caring attitude of the staff and that the staff who took time to listen effectively. Comment cards also included positive comments about being pleased with the on-going care arranged by practice staff.

These findings were reflected during our conversations with patients. The feedback from patients was positive.

Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients told us they are happy, very satisfied and said they got good treatment. Patients knew how to complain but told us they had no complaints.

Patients told us there were some on-going issues with the repeat prescriptions system. Patients were aware the practice was working to improve the prescription system so patients received repeat medicines in a timely way.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands. Although most consulting rooms were on the first floor, patients told us they could request to be seen in a ground floor consulting room if they had mobility problems.

Areas for improvement

Action the service SHOULD take to improve

The practice should consider storing records of the audits centrally to provide a resource for students, trainees and staff at the practice.

Devon Square Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a second CQC inspector, a GP specialist advisor and an Expert by Experience. Experts by Experience are people who have experience of using care services. They take part in our inspections and spend time talking to patients. They also observe the environment.

Background to Devon Square Surgery

Devon Square Surgery provides primary medical services to people living in Newton Abbot and the surrounding areas. At the time of our inspection there were 8,520 patients registered at the service with a team of seven GPs meeting patients' needs. Five of these GPs are partners. In addition there are three registered nurses, and three health care assistants. Patients who used the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice provided services to a diverse population age group. The practice employed a practice manager and a team of clerical and administration staff.

Devon Square Surgery is open between Tuesday and Friday: 8.00am – 6.00pm and open from 7:00am – 7:30pm on Mondays.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

How we carried out this inspection

Before conducting our announced inspection of Devon Square Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England and the local clinical commissioning group. We also requested information and documentation from the practice, which was made available to us either before or during the inspection.

We carried out our announced visit on Thursday 10 July 2014. We spoke with ten patients and nine staff employed at the practice during our inspection, which included the practice manager, GPs, nurses, health care assistants and administrative staff. We also spoke with a representative from the practice's patient participation group (PPG) and a person representing patients registered at the practice who were living in a nearby care home. We collected two patient responses from our comments box which had been displayed in the waiting room.

We observed how the practice is run and looked at the facilities and the information available to patients. We looked at documentation that related to the management of the surgery and at parts of anonymised patient records

Detailed findings

to look at processes followed by the staff. We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

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

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

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

Are services safe?

Our findings

Safe Patient Care

Staff were aware of the significant event reporting process and how they would escalate concerns within the practice. All staff we spoke with felt very able to raise any concern, however small, with the team as a whole. Staff also demonstrated knowledge that following a significant event, the practice undertakes a Significant Event Analysis (SEA) to establish the full details of the incident and the full circumstances surrounding it.

There were systems in place to make sure any medicines alerts or recalls were actioned by the practice manager and lead prescribing GP. However, there was no central place on the computer for receiving and cascading this information from medicines safety agencies to all GPs. There was also no system for recording that all GPs (including locums) had been made aware of any new medicine safety alerts.

Learning from Incidents

Two events were discussed to understand how the practice learnt from incidents and made changes to the practice where appropriate. One issue related to patient care and a missed follow up x-ray. There was evidence that learning took place from the examination of the incident. However, because of the recording system used it was unclear whether learning had been cascaded to all GPs in the practice.

Discussion with the GPs revealed that there was a forum to learn from events in weekly clinical meetings. However, as incidents were not routinely timetabled on the agenda as a standing item, there was risk of incidents being missed from the meeting.

Safeguarding

Patients told us they felt safe at the practice and knew how to raise any concerns.

A named GP had a lead role for both safeguarding older patients and children. They had been trained to the appropriate level (level 3). There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local safeguarding team. These details were displayed where staff could easily find them.

There were monthly meetings with other community based health professionals. Health care professionals were aware they can raise safeguarding concerns about vulnerable adults at these meetings.

Staff said communication between health visitors and the practice was good and any concerns are followed up. For example, if a child looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

The computer based patient record system allowed safeguarding information to be alerted staff. This meant that in the event a vulnerable adult or 'at risk' child is seen by different clinicians, all would be aware of their circumstances and this important information would not be lost. The staff told us they had received safeguarding training, which training records confirmed. They told us they are aware of who the safeguarding leads were and demonstrated knowledge of how to make a referral or escalate a safeguarding concern internally.

Monitoring Safety & Responding to Risk

The building was owned by the GP partners. Consideration was being given to the on-going suitability of the premises in terms of accessibility and growing patient list sizes. The practice had a risk assessment in place which related to fire hazards and health and safety.

The practice had a suitable business continuity plan that documented the surgeries response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment and being able to work from another nearby surgery.

Medicines Management

Patients were informed of the reason for any medicines prescribed and the dosage. Where appropriate patients were warned of any side effects. For example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medicine to check for side effects.

Patients were not completely satisfied with the repeat prescription processes because of perceived delays in getting their prescriptions. The practice acknowledged they were working to resolve issues. Patients were notified of health checks needed before medicines were issued. Patients were aware that to gain repeat prescriptions they

could use the box in the practice, send an e-mail, or use the recently introduced on-line facility. Patients also explained they could collect their medicines from the pharmacy which is located close to the practice.

The GPs were responsible for prescribing medicines at the practice. There were no nurse prescribers employed. We saw that medicines and prescription pads were stored safely. All prescriptions were authorised by the prescriber.

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

There were appropriate arrangements for medicines management including those medicines requiring cold storage. There were systems in place so that checks took place to ensure medicines were kept within their expiry dates. Those medicines which required refrigeration were stored in secure fridges. Fridge temperatures were monitored daily to ensure that medicines remained effective.

We conducted a visual check on a sample of medicines to check they were in date. This included checks on emergency medicines. One box of medicine had passed its expiry date and was removed by the staff during the inspection. We also checked emergency equipment with the nurse. The resuscitation kit, additional portable kit, defibrillator and oxygen were all in order.

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received two completed cards. They commented on the building being clean and tidy. Patients told us staff used gloves and aprons and washed their hands.

The practice had policies and procedures on infection control and these had been recently reviewed. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. We spoke with duty nurses and health care assistants (HCAs) who described the steps they took in between patient appointments, such as changing gloves, hand-washing, changing bed roll, and wiping the couch, to reduce risks of cross infection.

We saw records of an infection control audit that had been completed in July 2014. This included an individual room audit. Discussion of the audit findings was timetabled on the agenda for the next staff meeting.

Treatment rooms, public waiting areas, toilets and treatment rooms appeared visibly clean. There was a written cleaning schedule for the cleaning staff. A system was in place to monitor cleaning routines and supervise cleaning staff.

Clinical waste and sharps were being disposed of in safe manner. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Waste was stored in a secure, external store cupboard.

Staffing & Recruitment

The practice had a low turnover of staff. The practice used locums to cover for GPs during staff absence.

Recruitment procedures showed staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

DBS (Disclosure and Barring Checks - formally Criminal Record Bureau check) are only currently performed on clinical staff, not administrative staff. There was no recorded risk assessment performed to explain this decision.

The practice had clear disciplinary procedures to follow should the need arise.

The registered nurses Nursing and Midwifery Council (NMC) status check was completed and checked annually to ensure they are on the professional register.

Dealing with Emergencies

There was a duty system in operation to ensure one of the nominated GP partners cover for their colleagues, for example emergency home visits and checking blood test results.

Appropriate equipment was available and maintained to deal with emergencies, for example if a patient collapsed. Administration staff appreciated that they had been

Are services safe?

included on the basic life support training sessions. They told us they were often in the position to notice if a patient was becoming rapidly unwell whilst sat in the waiting room.

Equipment

We looked at the emergency medicines and checked whether they remained safe to use. We also checked that emergency equipment had been serviced or safety tested. We saw that equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were serviced and calibrated where required.

Emergency equipment available to the practice was within its expiry date. The practice had a system using checklists to monitor the expiry dates of medicines and equipment.

We spot checked medical supplies such as blood bottles, swabs, needles and syringes. There was some out of date stock in two of the five consulting rooms we checked. We brought this to the attention of the practice manager and the items were removed immediately. They said they would ensure a robust system for ensuring equipment was in date and suitable for continued use would be implemented without delay.

Portable Appliance Testing (PAT) is a safety test for electrical appliances and is required every two years. Those checks had been carried out by an external contractor. Records showed tests had been completed.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting Best Practice

We saw examples where care and treatment followed national best practice and guidelines. For example, we saw that where required, guidance from the Mental Capacity Act 2005 had been followed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that it generally achieved high scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed in line with other surgeries and practices within the CCG.

The clinical care pathways for patients with respiratory diseases, diabetes and asthma were GP led at the practice. The nursing staff carried out health screening but the management of these patients was done by the GPs. GPs told us this meant they could provide a better continuity of care.

The practice used a range of assessments to audit clinical outcomes. However, the effectiveness of audits was hampered by disorganised electronic records and restricted access to electronic records. Filing and access to audits depended upon who had set them up in the computer system and this made assessment of the system for monitoring clinical outcomes, at times, difficult.

Management, monitoring and improving outcomes for patients

The practice was keen to ensure that staff had the skills to meet patient's needs. For example, each member of staff had an annual appraisal where they were able to identify particular professional interests and training needs. Staff told us that the practice manager supported them to attend courses to meet their individual professional interests and the needs of the patient population, for example dementia training.

Staffing

All of the doctors in the practice participated in the appraisal system leading to revalidation over a five-year cycle. The GPs we spoke with told us these appraisals have been appropriately completed. Nursing and administration staff had been scheduled in for an annual formal appraisal and they kept up to date with their continuous professional development programme. We saw documented evidence to confirm this process was robust. We saw a comprehensive induction process for new staff.

Staff felt well supported in the training programme. We saw the staff training record which showed that all staff were up to date with mandatory training including basic life support, infection control, confidentiality, customer care and data protection. Staff said that they could ask to attend any relevant external training to further their development.

Working with other services

There were monthly meetings with community health professionals to discuss vulnerable and high risk patients and those receiving end of life care. The IT system facilitated the transfer of data with all six of the local practices. This meant if a patient moved within the group there was continuity with recording in their electronic records. The system also allowed for recording of data by community midwifes, health visitors and district nurses within the same system. The GP was then able to see an overview of the patient's health needs and support.

The practice website detailed how patients could access further services. These included the minor injuries unit, physiotherapists, occupational therapists, speech and language therapist, X-rays, health visitor and chemist.

Health Promotion & Prevention

Well women and man clinics and vaccination clinics were offered. This enabled the GPs to recommend lifestyle changes to patients and promote health improvements which might reduce dependency on healthcare services.

Patients were supported and educated to monitor their own conditions, especially older or younger patients with chronic conditions. This included information sharing and lending blood pressure monitoring equipment..

There were a range of leaflets and information documents available for patients within the practice and on the website. These included leaflets for mental health issues, smoking cessation, diet, how

to live a healthy lifestyle and support groups such as domestic violence support. The practice website had links

Are services effective?

(for example, treatment is effective)

for patients to follow which included how to obtain urgent medical advice and support, healthy lifestyle, holiday health and self-treatment of common illness and accidents.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Ten patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff.

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received two completed cards which contained detailed positive comments. Patients were grateful for the caring attitude of the staff and for the staff who took time to listen effectively. Patients expressed confidence in the advice and medical knowledge given at the practice.

Comment cards also included positive comments about the continuity of care, not being rushed at appointments and being pleased with the on-going care arranged by practice staff.

We saw that patient confidentiality was respected within the practice. There were areas available should patients want to speak confidentially away from the reception area. We made numerous observations throughout the day of reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and always conducted behind a closed door. Window blinds, sheets and curtains are used to ensure patient's privacy.

We discussed the use of chaperones to support patients when examinations or consultations were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. There were notices in the patient waiting areas and in clinic rooms informing patients that they were entitled to have a chaperone present for any consultation, examination or procedure where they felt one was required. The practice had a written policy and guidance for providing a chaperone for patients which included expectations of how staff are to provide assistance. Health care assistants and reception staff at the practice told us that they acted as chaperones as required and that they understood their role is to reassure and observe that interactions between patients and doctors are appropriate. Having these systems in place meant there were appropriate systems in place to respect and maintain patient's privacy and dignity.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback from the comment cards showed that patients had different treatment options discussed with them, together with the positive or possible negative effects the treatment may have.

Patients told us that nothing is undertaken without their agreement or consent at the practice.. Staff knew patients well and were able to communicate well with them. The practice staff knew how to access translation services to ensure information was understood by patients to enable them to make an informed decision or to obtain consent to treatment.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice acted in accordance with the Mental Capacity Act 2005. Alerts on patient records also flagged up important information to inform staff as to which family member they are able to share information with.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice had open waiting areas and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. The reception staff were pleasant and respectful towards the patients.

Patients we spoke with told us they felt the practice were responsive to their individual needs. They told us that they had been visited at home when appropriate and they felt confident the service would meet their needs. GPs told us home visits were allocated in relation to GPs personal lists if possible.

We saw the practice responded to changing patient needs. For example, extended opening hours one day a week was introduced as a result of feedback from patients who work and found it difficult to attend appointments during work hours.

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

An effective process was in place for managing blood and test results from investigations. Patients said their test results had been either given immediately, phoned through by a GP, sent by letter or supplied when they phoned the practice. Everyone was certain that there was no delay no matter which method was used.

Access to the service

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. The number of GPs was slightly under the Devon average for the patient list size. The practice manager told us the practice used locum GPs to cover this shortfall. The practice was in the process of developing a staff succession plan to take into account known and anticipated staff changes in the future in order to ensure patients received appropriate care during staff changes.

The practice was involved in a trial of a new booking system during 2013. Feedback from patients was that they did not find this new system user friendly. As a result the system was abandoned and the practice re-implemented its previous booking system, with some additions from the trial system that patients liked. Patients told us the booking system now worked well. Patients particularly liked being able to have a telephone consultation if they felt a visit to the practice wasn't necessary for them.

Recent changes to the repeat prescription ordering system had resulted in some problems for patients not receiving their medicines in a timely way. The practice acknowledged this had been problematic and had worked to resolve the issues. Patients told this was improving.

In addition to the practice website, a practice information welcome leaflet for patients was available in the reception area. This contained information on the services provided by the practice, staff employed, opening times, appointments, home visits, out of hours care, how to complain and telephone call back services.

Concerns & Complaints

Patients we spoke with indicated that they knew how to make a complaint. The practice manager had an open door policy for patients to discuss any concerns.

Information on how to raise a complaint or concern was displayed within the practice and information was also available on the provider's website. The process included timescales in which the practice would respond and information about other regulatory bodies to whom patients could complain.

We saw that the provider had an effective complaints procedure in place and we reviewed the complaints file. A paper file was kept to record complaints and an annual return was sent to the NHS Commissioning Board local area teams. The practice manager was in the process of standardising the complaints template to show learning more effectively, including the creation of an electronic file for complaints to provide and overview for comparison of complaints trends.

Are services well-led?

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

Our findings

Leadership & Culture

We spoke with GPs, nurses, and administrative staff during the inspection. All spoke highly and respectfully of their colleagues, their employment at the practice and the standard of leadership they worked under. There were clear lines of accountability and staff are aware of each other's roles and responsibilities. All said that the GP partners and practice manager are approachable and said there was a strong team ethos throughout the practice. All of the staff we spoke with made very positive references to the open culture within the practice.

Governance Arrangements

Structured meetings ensured information was shared. GP partners, the practice manager and nurses met weekly to discuss clinical issues and matters relating to the running of the practice such as staffing and complaints. This ensured that matters that may have an impact on patient care and safety were discussed to ensure awareness and effective service delivery.

There were separate practice nurse meetings for nursing staff to catch up, share information and feedback. These often had a training or educational aspect.

The practice had a range of appropriate policies and procedures to inform clinical practice and maintain safety. We noticed the emergency medicines stock policy did not match current stock intended for use in an emergency. We brought this to the attention of the practice manager, who told us the policy would be reviewed and amended to reflect the stock that was routinely held.

Systems to monitor and improve quality & improvement

The quality of care is reflected in the practice achievements against the Quality and Outcomes Framework (QOF) although there was no specific QOF lead in the practice. Each clinician addressed the variable QOF domains. We discussed with the practice manager adoption of specific clinician QOF roles with forthcoming anticipated changes to staff personnel and addition of new staff with specific clinical interests.

The clinical auditing system assisted in driving improvement. It was hampered by poor organisation of electronic records of completed audits which made it difficult to access audit results and identify trends. Administration staff felt supported to raise concerns and highlight when the business did not run effectively. For example, staff had felt confident raising issues about the trial of a new appointment booking system and changes to repeat prescription ordering.

Patient Experience & Involvement

The practice recognised the importance of patient feedback and ensured that feedback mechanisms were advertised and easily accessible.

The practice had a patient participation group (PPG). We spoke with a representative who told us the group had approximately 40 members. The chair of the group met with the practice manager every two months. They described the practice manager as approachable and dedicated to hearing patient's views in order to improve experiences for patients registered at the practice.

Identification & Management of Risk

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. Risk assessments had been completed for health and safety risks relating to the building. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Patients over the age of 65 told us they were pleased with the care they received.

There were not specific older person clinics held at the practice, but treatment was organised around the individual patient and any specific condition they had. For example, the practice held clinics for both carers and people suffering with dementia.

Routine vaccination clinics for pneumonia and flu were organised at the practice in the autumn. These included any patient over the age of 65.

Home delivery of prescriptions was arranged for some older vulnerable patients.

The practice had a system to identify older patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for older people approaching the end of life.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

We found patients with long term illnesses had their condition and medication reviewed when required. GPs also supported and trained patients to monitor their own conditions, especially older patients with chronic conditions but also younger patients. The practice had a carers' register and all carers were contacted by telephone to offer them an appointment for a carers' check with nursing staff. Newly registered patients who are carers were informed of the service. Specific staff training had been given for this.

Staff worked effectively with other agencies in relation to long term conditions. For example, if it was apparent patients needed other equipment, grab rails or treatment, staff made contact with occupational therapy and physiotherapy teams. GPs with specialist training in substance dependency also liaised with community based drug and alcohol teams to support and manage people with substance addictions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

Parents we spoke with were very happy with the care their families received.

There were well organised baby and child immunisation programmes available to ensure babies and children could access a full range of vaccinations and health screening.

Ante-natal care was accessed through a team of midwives who work with the practice. Midwives held sessions at the practice twice a week. Systems were in place to alert health visitors where children did not attend routine appointments and screening.

Appropriate systems were in place for the identification and referral of safeguarding matters that related to children and young patients.

The practice referred patients and worked closely with a local family and child service to discuss any vulnerable babies, children or families.

Women and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. There were quiet private areas in the practice for women to use when breastfeeding.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

There were extended opening hours on a Monday (from 7am – 7:30pm) where patients who work were able to access early morning and evening appointments. Extended opening hours were arranged in response to feedback about opening hours from working patients registered at the practice.

Suitable travel advice was available from the clinical staff within the practice and supporting information was provided within the waiting areas.

The staff carried out opportunistic checks on patients as they attend the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews.

The staff carried out opportunistic health checks on patients as they attend the practice. 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.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice offered a service to patients with substance misuse. GPs involved had a special interest and training to support these patients.

There were care homes for older people and people with learning disabilities in the area. Annual health checks were offered to these patients including home visits, if this was appropriate.

Vaccinations were offered when required and managed safely. Appropriate arrangements were in place to ensure that patients with mobility limitations had access to care.

Staff told us that there were a few patients who had a first language that was not English. Patients with interpretation requirements were known to the practice and staff knew how to access these services.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

Routine care appointments for patients experiencing a mental health problem were available and advanced bookings could be made if required.

The practice evidenced they were responsive in making referrals for mental health concerns through patient feedback and records.

Liaison was undertaken with external agencies, for example the mental health crisis team, local support groups and counsellors when required.

GPs and nurses were aware of the Mental Capacity Act and had received training on this. There were nationally recognised examination tools used for people who were displaying signs of dementia.