Grosvenor Road Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Grosvenor Road surgery on Wednesday 1 April 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all of the population groups. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Clinical risks to patients were assessed and well managed. However, environmental risks and those relating to recruitment checks were not well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice was well equipped to treat patients and meet their needs but the environment was in need of renovation in places.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Action the provider MUST take to improve:

The provider must ensure recruitment procedures are established and operated effectively.

Ensure the premises are safe and suitable for their intended purpose by carrying out a fire risk assessment and provide evidence that staff have attended fire safety training and practiced regular fire drills.

Action the provider SHOULD take to improve:

Have systems in place to monitor the distribution of prescriptions once they leave the secure storage facilities.

Ensure that environmental risk assessments are detailed and contain ratings and mitigating actions to reduce and manage the risk.

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?

Requires improvement 

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements.

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

Although risks to patients who used services were beginning to be assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, recruitment procedures were not robust and fire safety procedures did not demonstrate that measures would protect patients and staff.

Are services effective?

Good 

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good 

The practice is rated as good for providing caring services.

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

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services.

The practice reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services

Summary of findings

where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice facilities were not always suitable for the numbers and needs of patients but was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

The practice had a clear vision and strategy despite many staff changes. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure in place. Staff felt supported by the GPs and by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems being introduced to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was starting to be used. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

Patients aged 75 and over had an allocated GP but had the choice of having an appointment with another GP if they preferred.

Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people. Vaccines for older people who had problems getting to the practice or those in local care homes were administered in the community by the practice nurses. The majority of all influenza vaccines were given during Saturday morning sessions which are administered by GPs and Nurses.

Nurses and doctors undertook home visits for older people and for patients who required a visit following discharge from hospital.

There were not specific older person clinics held at the practice. Treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older frail or vulnerable patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. This included a community matron for the elderly in the community. The practice website included a number of links containing extensive information about the promotion of health for conditions which affect older people.

The practice worked to avoid unnecessary admissions to hospital and worked with other health care professionals to provide joint working. The GPs had direct access to a consultant geriatrician for advice on the best treatment and advice, including whether it was appropriate for the patient stay in the community. The GPs were also involved in an acute geriatric intervention service. This was a joint community service with the ambulance service where GPs, community staff and the local ambulance service visited the patient at home to assess the best course of treatment to avoid admissions to hospital.

The practice liaised with local pharmacies to provide medication in blister packs for patients with memory problems.

The practice was arranged on multiple levels. Stair-lifts were available for those that can manage them with the assistance of a member of staff. The GPs were also happy to move downstairs to see patients who were not able to get upstairs. Chairs in the waiting room had been changed to include some with arm rests to assist patients to stand.

Summary of findings

Housebound, nursing and residential home patients had an annual review done in their home by a relevant clinician. This review included chronic disease review, medication review, nutrition review, and also addressed any problems or concerns the patient had. This was done in addition to visits performed.

People with long term conditions

Good

The practice identified patients who might be vulnerable, have multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. The staff at the practice maintained links with external health care professionals for advice and guidance. Patients with long term conditions have tailor-made care plans in place.

The practice called in every patient with any combination/or single long term condition for a "birthday review". Patients had an initial consultation which consisted of lifestyle advice being given and basic examinations being performed, for example weight and blood pressure. Patients were then seen by the GP or specialist Nurse. Additional appointments were added as required. The nurses attended educational updates to make sure their lead role knowledge and skills are up to date. Practice staff also involved healthcare specialists for advice where appropriate.

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 was a weight management referral service for patients to attend and they could also be referred to dieticians should it be necessary. The service offered was a level 2 and 3 obesity service.

There were weekly diabetic 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.

There were fortnightly Gold Standard Framework meetings with multi-disciplinary team members, and also monthly Primary Care Team meetings regarding patients with concerns outstanding.

The practice computerised patient record system could be accessed by the local 'BIG' Team, which was a group of local GP's and Nurses who dealt with complex patients in a proactive way before they reached crisis.

Summary of findings

Families, children and young people

Good

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. These included the 8 week check for both mother and child, along with the immunisation clinics.

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held clinics at the surgery had access to the patients' computerised notes and could speak with a GP should the need arise. The practice also had effective relationships with health visitors, the school nursing team, and were able to access support from children's workers and parenting support groups via the health visitors. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

The practice had monthly safeguarding meetings to discuss vulnerable children or families, especially those subject to child protection plans. These meetings were attended by the GPs, Midwife, Health Visitor, School Nurse, Practice Nurse and Nurse Practitioner allowing for broad input.

Patients 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 which can be made available for women to use when breastfeeding.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Working age people (including those recently retired and students)

Good

Patients who are of working age or who have recently retired were pleased with the care and treatment they received, this was shown in the Friends and Family survey which had been undertaken.

Advance appointments (up to six weeks in advance) and Saturday morning appointments were available three out of four weeks to assist patients who were not able to access appointments due to their work times. There was an online appointment booking system, which patients said was useful.

There was a virtual patient participation group at the practice which had a high number of working age members. They used electronic communication to provide feedback to the practice.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available within the waiting areas.

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. This gave the practice the opportunity to assess the risk of serious conditions on patients which attend. The practice also offered age appropriate screening tests including 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 and used the electronic prescription service. The local pharmacies collected prescriptions from the practice each morning.

The practice provides sports medicine expertise for young people and promoted healthy lifestyles.

People whose circumstances may make them vulnerable

Good

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

Practice staff were able to signpost patients with alcohol problems and addictions to Torbay alcohol service for support and treatment. The same applied to patients with drug problems who had access to a weekly drop in service at the library. There were also occasions when these patients were also seen within the practice by this team.

The practice worked with a community matron who visited any vulnerable patients at their home to assess and facilitate any equipment, mobility or medication needs they may have and to advise about treatment.

People experiencing poor mental health (including people with dementia)

Good

A register at the practice identified patients who have mental illness or mental health problems.

Patients had access to an anxiety and depression service and were monitored when they had depression. These appointments were conducted within the practice and in the community. Patients who had depression were seen regularly. There was also a mental health team available for more severe conditions including a memory clinic for dementia patients.

Summary of findings

In house mental health medication reviews were conducted to ensure patients received appropriate medication. Blood tests were regularly performed on patients receiving certain mental health medications. These patients were called in the same basis as those with chronic conditions.

The practice used nationally recognised examination tools used for people who are displaying signs of dementia.

Summary of findings

What people who use the service say

We spoke with 15 patients during our inspection.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 25 comment cards. Comment cards were detailed. There were three cards which negative comments. These related to trouble getting through on the telephone and one comment about a carpet at the practice. There were no negative comments about the staff or care. Positive comments indicated that patients appreciated the good care, professional staff and appointment system. Patients made reference to the good care they received, the dignity and respect they were shown and praised the staff who listened and provided thorough treatment and care.

These findings were reflected during our conversations with the 15 patients we spoke with and from looking at the practice's 78 friends and family test results from January 2015 to March 2015 and from the practice patient survey from earlier this month.

The feedback from the patients we spoke with was mostly good. Patients told us about their experiences of care and praised the level of care and support they received at the practice. Patients said they were happy, satisfied, said they had no complaints and received good treatment. The majority of patients told us that the GPs and nursing staff were excellent.

Of the 84 friends and family test results we saw 78 patients said they were extremely likely or likely to recommend the practice. There were many positive comments to support the findings. Negative comments related to the lack of parking at the practice.

Patients were happy with the appointment system. We were told patients could either book routine appointments two weeks in advance or could make an appointment on the day. We were told that no patient would be turned away and that patients would always be fitted in should the day time appointments be full. One patient said they made an appointment at 5pm the day before their morning appointment.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients were mostly satisfied with the facilities at the practice but said the building was in need of redecoration and that the lack of parking was a problem. Patients commented on the building always being clean. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients said they found it easy to get repeat prescriptions processed. Patients said this was done by depositing the request in the box at reception, by telephone, auto-renewal by pharmacy or on-line. The usual time delay was one to two days.

Areas for improvement

Action the service MUST take to improve

The provider must ensure recruitment procedures are established and operated effectively.

Ensure the premises used by the service provider are always safe to use for their intended purpose. For example, by carrying out a fire risk assessment and provide evidence that staff have attended fire safety training and practiced regular fire drills.

Summary of findings

Action the service SHOULD take to improve

Have systems in place to monitor the distribution of prescriptions once they leave the secure storage facilities.

Ensure that environmental risk assessments are detailed and contain ratings and mitigating actions to reduce and manage the risk.

Grosvenor Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Grosvenor Road Surgery

Grosvenor Road Surgery was inspected on Wednesday 1 April 2015. This was a comprehensive inspection.

The main practice is situated in the seaside town of Paignton, Devon. The practice is one of two practices who come under the Paignton Medical Partnership. Together, the practice provides a primary medical service to approximately 8,100. Grosvenor Road provide primary medical services to 5,500 patients of a diverse age group. The practice also see additional temporary residents per year. The practice is a training practice for doctors who are training to become GPs.

There is a team of three GP partners and one salaried GP within the organisation. Partners hold managerial and financial responsibility for running the business. There were two male and two female GPs. The team were supported by a practice manager, a business manager, five practice nurses, two nurse practitioners, four phlebotomists (staff who take blood) and a nurse assistant. 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.

The practice is open from Monday to Friday, between the hours of 8.00am and 6.00pm. Appointments are available to be booked up to six weeks in advance and take place between 8.30 and 17.30 but telephone consultations sometimes take place from 8.00am. Saturday morning appointments between 9am and 11.20am are available three Saturdays out of four for people who are unable to access appointments during normal opening times.

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

Why we carried out this inspection

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

How we carried out this inspection

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

Detailed findings

• 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

Before conducting our announced inspection of Grosvenor 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 South Devon and Torbay CCG.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 1 April 2015. We spoke with 15 patients, three GPs, four of the nursing team and members of the management, reception and administration team. We collected 25 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the 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.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff explained they were required to complete a 'log' on the computer system which was then seen by the GPs and practice manager for action. This was then reviewed at the monthly clinical governance meetings. Staff said the process was open and supportive.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We asked to see safety records, incident reports and minutes of meetings where these were discussed. These did not always formally show how the practice had actioned these or learnt from them. The business manager had started to keep a summary of these events to monitor trends.

Significant events were a standing item at the clinical governance meeting. Staff were able to give examples where the practice had learned from these and findings were shared with relevant staff but records did not always show this action had taken place. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff were able to give examples of the action taken as a result of significant event. For example, relating to communication regarding a vulnerable child. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the business manager or GPs to practice staff by email or memo. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. These were then discussed at the clinical governance meetings and nursing meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. 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. Contact details were easily accessible using the flow charts displayed in clinical areas.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. GPs had attended level three training and nursing staff had attended level 2 training.

There was a 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 or information about vulnerable patients.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone.

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. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and maintained records to show this process was followed each day.

The practice employed a nurse assistant who was responsible for the stock control of medicines, vaccines and immunisations. Processes were followed to check

medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Clinical Commissioning Group (CCG) data showed that the practice was a high performer with regard to prescribing. Practice staff used CCG guidance and the CCG formulary to ensure they were prescribing within acceptable ranges. One of the GPs was nominated the lead for prescribing. We saw records to show she cascaded information from the CCG prescribing meetings to other GPs at the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date signed copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision, appraisal and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were stored in accordance with national guidance. However, these were not always tracked through the practice.

The practice held stocks of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. There were standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. A controlled drug register was maintained and checked on a regular basis. There were arrangements in place for the destruction of controlled drugs.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place which had been introduced in the last two weeks. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control but said that some carpets in consulting rooms were looking tired.

The practice had a lead 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 received E learning training about infection control specific to their role and received annual updates.

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, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. This had been written following an audit earlier this month of all clinical areas. This had highlighted a change in where waste bins were located and the introduction of disposable curtains. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice had last carried out a check this month, in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Nursing staff told us that all clinical equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We did not see records to show that portable electrical equipment was routinely tested, although staff said this had been done recently. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However, this was not always followed.

Requires improvement

Are services safe?

Records we looked at were disorganised and did not contain evidence of all recruitment checks had been undertaken prior to employment. For example, we looked at four staff files. None of which contained references. One member of staff had been employed within the last year. The practice manager explained that the person had been taken on as a temporary member of staff so these checks were not done. There were no interview records seen to show that the procedure was consistent and met equal opportunities. All files contained proof of identification, qualifications, and registration with the appropriate professional body. However, these checks had not been kept under review. For example one nurse's file showed this check had last been done in 2013. All files for nurses and GPs contained evidence of and criminal records checks through the Disclosure and Barring Service (DBS). The strategic business manager provided a risk assessments used at the practice to explain why criminal records checks had not been performed on administration or reception staff.

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.

Monitoring safety and responding to risk

The practice had written a health and safety policy in the last week which had not yet been implemented. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Risk assessments had been performed by the new Strategic Business Manager who had been in post for two weeks and had identified these had not been done for a length of time. He had begun to identify risks throughout the building. However, these risk assessments had not all been rated and did not contain mitigating actions to reduce and manage the risk. We were told there was a health and safety lead at the practice but not all staff were aware of who this was. Staff said that any risks within the building would be discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available on both floors and included access to oxygen and an automated external defibrillator (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.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice employed a nurse assistant who had efficient processes and records in place to demonstrate that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, this was a generic document which had not been adapted for the practice yet. Each risk was listed and contained actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had not carried out a fire risk assessment and did not provide evidence that staff had attended fire safety training or had practiced regular fire drills. Staff said they had just started to do fire safety e Learning. There was an office on the top floor which did not have a structured fire escape. Portable ladders were provided for emergency evacuation. There were no fire detection systems in place for this room. We passed this information onto Devon & Somerset Fire & Rescue Service who told us they would visit the practice.

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. New guidelines were disseminated and the clinical governance meetings and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. 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. Staff explained they used these guidelines to influence the care templates they used at the practice.

The GPs and practice nurses told us they lead in specialist clinical areas such as diabetes, heart disease and asthma, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

The GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was significantly better to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

National data showed that the practice was performing better than other practices in the CCG area for referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw an audit to show reviews of elective and urgent referrals were appropriate.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us three clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the service they provided was appropriate. For example, referral rates were appropriate. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of medicines for patients who were taking a medicine used in neuropathic pain, anxiety disorder, and partial epilepsy. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. Staff also discussed the audit findings at the clinical governance meetings to ensure prescribing practices were appropriate.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 90.87% of patients with diabetes had an annual health review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

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.

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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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 fortnightly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with performing mandatory eLearning courses such as safeguarding and infection control. All staff had received annual basic life support. We noted a good skill mix among the GPs with one having an additional diploma in sports medicine. One GP practiced hypnotherapy. All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and travel health. Those with extended roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It 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. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings every two weeks to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice also held safeguarding meetings which were attended by midwives, health visitors and social workers to discuss children on the at risk register. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We spoke with a health visitor who was at the practice on the day of our inspection. They also said the meetings were invaluable.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was 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, and the practice made of referrals last year through the Choose and Book system. (Choose and Book is

Good

Are services effective?

(for example, treatment is effective)

a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and had received training for this. The staff were also aware of the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had worked with other healthcare professionals, for example with patients with learning disabilities. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually around the time of the patients birthday. For example last year 40 of the 41 patients with learning disabilities had attended for a health care review. The remaining patient had declined. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy and systems in place for documenting consent for specific interventions such as ear syringing and cervical smears. For example, for all minor surgical procedures, a patient's written consent was documented and scanned into the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

New patients were offered a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among 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 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 157 patients in this age group had taken up the offer this year of the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 526 of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 29, which was above average compared to neighbouring practices and national figures. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 90.4%, which was better than others in the CCG area. 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 immunisations was above average for the CCG. For example 100% of the eligible children had received the recommended vaccinations in the first 12 months of their

Good

Are services effective?

(for example, treatment is effective)

life. The remaining data for immunisations showed the practice performed higher than other practices in the CCG. There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from March 2014 and a practice survey performed in March 2015. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated well above average for its satisfaction scores on the GPs treating patients with care and concern. For example 92.5% compared to the national average of 85.3%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive about the environment and getting through on the telephone. We also spoke with 15 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private and prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained despite the small waiting room.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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 88.93% of practice respondents said the GP involved them in care decisions in comparison to 81.83% of the national average results. The results from the practice's own satisfaction survey showed that 81% of patients said they were sufficiently involved in making decisions about their care.

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.

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, patients we spoke with on the day of our inspection and the

Good

Are services caring?

comment cards we received showed that patients had received help to access support services to help them manage their treatment and care when it had been needed.

Notices and leaflets in the patient waiting room, information on the TV screen and the patient website 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.

Staff told us that if families had suffered bereavement, their usual GP contacted them. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. For example, a comment card referred to the care and treatment a relative had received being exemplary and the pre and post bereavement care being excellent.

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 patient'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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw records of significant events and complaints which had been shared with the local CCG.

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). For example, following a merger with another practice in the town the practice had carried out a patient satisfaction survey to ensure patients were happy with the merger. This had highlighted that some patients had been unaware of the merger and had resulted in additional communication by newsletter and website.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, local nursing homes and care homes. As a result the GPs had been allocated to be the named GP for each home in the area. This had resulted in better continuity of care for the patients and staff.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The strategic business manager explained that the practice was meant to be moving to a new premises but this had not happened. We noted that the premises was not purpose built but had been adapted to meet the needs of patient with disabilities and mobility issues. For example, a stair lift was in place to assist patients reach the first floor consultation rooms. We saw a GP come to see a patient on the ground floor to save the patient from getting upstairs. Waiting rooms were restricted in size so were difficult to negotiate for patients with prams or patients in wheelchairs. Treatment rooms and consultation rooms were of a good size. Staff said the building did cause problems at times because of the lack of space. Patients said the building was in need of redecoration and repair. The GPs explained that a plan of renovation was now in place now that the new building plans were now not going ahead.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice is open from Monday to Friday, between the hours of 8.00am and 6.00pm. Appointments were available to be booked up to six weeks in advance and took place between 8.30 and 17.30. Telephone consultations sometimes took place from 8.00am. Saturday morning appointments between 9am and 11.20am were available three Saturdays out of four for people who were unable to access appointments during normal opening times.

Comprehensive information was available to patients about appointments on the practice website and within the patient leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes, by a named GP and to those patients who needed one.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see anotherGP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they contacted the practice at 5pm requesting an urgent appointment and were booked in the next morning.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 business manager was the designated responsible person who handled all complaints in the practice.

Information was available in the patient handbook and on the website about how patients could make a complaint. However, nothing was displayed in the waiting area.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 12 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and explained in the practice statement of purpose document. The practice vision and values included to be kind, caring and professional and to be a welcoming, patient focused surgery with a strong emphasis on team working.

We spoke staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff said the last two years had been difficult because of staff changes and news that they were not moving to new premises. However, staff all stated that they thought team morale had remained high and the level of care had been unaffected.

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. However, not all of the policies had been kept under review. The strategic business manager explained that he had been in post for two weeks and had identified where updates were required. For example, the business continuity plan. All staff knew how to access the policies.

There was a new management structure in place. The practice had been without a day to day manager since December 2014. There were clear clinical leadership structures in place with named members of staff in lead roles. For example, there was a GP who was the lead for safeguarding. There was a nurse lead for infection control. We spoke with members of the administration and nursing team who were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly clinical governance meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, we noted that the majority of these were incentive driven.

The practice held monthly governance meetings. Staff explained there was a clear structure in place to make sure that performance, quality and risks had been discussed. However, records were not always kept to demonstrate these discussions.

Leadership, openness and transparency

Staff explained that team meetings were held regularly, at least monthly. 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, clinical governance meetings or informally.

Seeking and acting on feedback from patients, 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 annual patient survey which showed that patients had not been aware of the nurse practitioner who worked at the practice. This had resulted in more communication to patients and receptionists offering the service when patients telephoned to make an appointment.

The practice had a small virtual patient participation group (PPG). The PPG had influenced the patient survey following the merger of the two practices. The results and actions agreed from these surveys were available on the practice website.

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.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training, peer support and mentoring. Nursing staff said that regular

Are services well-led?

Good

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

appraisals took place which included a personal development and training plan. Staff told us that the practice was very supportive of training and that they had never been refused training related to their role.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and clinical governance meetings to ensure the practice improved outcomes for patients. For example one significant event affected the GPs, nursing team and administration team. All staff were reminded of correct procedures and measures put in place to prevent the situation arising again. Another example of learning was where the GPs used the death register actively to identify patients who had recently died. A selection of these patients were reviewed routinely to identify learning regarding clinical care leading up to the death and any additional support regarding bereavement care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Schedule 3- Recruitment procedures were not established or operated effectively. The following information was not available in relation to each such person employed— Recent photograph, satisfactory evidence of conduct in previous employment and system in place to monitor nursing registration.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The premises used by the service provider are not always safe to use for their intended purpose. There had been no fire risk assessment performed and there was no evidence provided to show that staff have attended fire safety training and practiced regular fire drills.