Ashburton 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.

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Overall summary

The Ashburton Surgery is located at 1 Eastern Road, Ashburton, Newton Abbot, Devon,TQ13 7AP. The practice provides health advice and treatment as well as referrals to other care agencies where necessary. The practice is open from 8:30am until 6pm Monday to Friday. A late evening surgery is available one evening a week for patients that find it difficult to visit the GP, nurse practitioner and nurse during the day. At weekends and when the practice is closed, patients are directed to the Out of Hours service delivered by another provider.

The practice has five GPs, a nurse practitioner, a practice nurse, an assistant practitioner and three phlebotomists (a person qualified to take blood). The GPs and nursing staff are supported by a team of administrative staff. They look after more than 6,000 patients in a rural area.

Staff were trained to support and work with vulnerable adults and children. There was appropriate equipment, medicines and procedures for managing patient emergencies. Staff were aware of policies and procedures for reporting serious events, accidents, errors, complaints, and for safeguarding patients at risk of harm. Incidents were investigated and acted on, and learning was shared with staff. Effective infection control measures were in place.

Patient care was delivered in line with best practice. Systems were in place to ensure the service was monitored and ways for improving the service for patients were explored. Systems were in place for recruiting new staff. The practice worked with other healthcare providers to ensure patients received effective care. Patients were offered advice, treatment and support for their health.

Patients described the staff as helpful and friendly. The receptionists had a warm and friendly approach to patients and visitors. They knew and understood the needs of patients who attended the practice regularly and their approach was kind. Patients told us they were involved in decisions about their treatment.

Patients were able to access the care they needed promptly and efficiently. The practice had systems to enable patients' views to be listened to and acted on. Arrangements were in place to help the practice meet the demand and needs of patients with minimal delay. Staff told us they had access to appropriate equipment to attend to patient needs. Staff were aware of arrangements for responding to medical emergencies. The practice was accessible to patients with mobility difficulties and those with young children.

A leadership structure and processes were in place to keep staff informed of any changes. The GPs and practice manager regularly reviewed complaints and significant events, to maintain and improve patient care. Staff felt valued and well supported. They were able to give their views on any improvements. The practice had responded to patients' views and patients gave positive feedback about the care provided.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Systems were in place to recognise and support patients who were at risk of abuse. Staff were trained to work with vulnerable adults and children. There was appropriate equipment, medicines and procedures for managing patient emergencies. Staff were aware of policies and procedures for reporting serious events, accidents, errors, complaints, and for safeguarding patients at risk of harm. Incidents were investigated and acted on, and learning was shared with staff.

Staff were aware of their roles and responsibilities regarding infection prevention and control and effective systems were in place.

Are services effective?

Patient care was delivered in line with best practice. Systems were in place to ensure the service was monitored and ways for improving the service for patients were explored. Systems were in place for recruiting new staff. The practice worked with other healthcare providers to ensure patients received effective care. Patients were offered advice, treatment and support for their health.

Are services caring?

Patients described the staff as helpful and friendly. The receptionists had a warm and friendly approach to patients and visitors. They knew and understood the needs of patients who attended the practice regularly and their approach was kind. Patients told us they were involved in decisions about their treatment.

Are services responsive to people's needs?

Patients were able to access the care they needed promptly and efficiently. The practice had systems to enable patients' views to be listened to and acted on. Arrangements were in place to help the practice meet the demand and needs of patients with minimal delay. Staff told us they had access to appropriate equipment to attend to patient needs. Staff were aware of arrangements for responding to medical emergencies. The practice was accessible to patients with mobility difficulties and those with young children.

Are services well-led?

A leadership structure and processes were in place to keep staff informed of any changes. The GPs and practice manager regularly reviewed complaints and significant events, to maintain and

Summary of findings

improve patient care. Staff felt valued and well supported. They were able to give their views on any improvements. The practice had responded to patients' views and patients gave positive feedback about the care provided.

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
Nursing staff were trained in the treatment of physical conditions that affected older people. The practice regularly held meetings with other agencies to discuss patient cases where end of life care needed to be considered. These meetings were held monthly and were attended by health visitors, hospice staff and community nurses. The cases discussed were mainly about elderly patients, but not exclusively so.

People with long-term conditions
The practice supported patients with long-term conditions such as respiratory disease and diabetes by offering screening, treatment and information. Regular monthly clinics were held for patients with long-term conditions.

Mothers, babies, children and young people
The practice supported mothers, babies, children and young people by working with other healthcare providers to provide maternity services and young children clinics. Students were able to attend a contraceptive clinic during the lunch time.

The working-age population and those recently retired
The practice had recognised that people who worked during normal office hours sometimes found it difficult to attend for appointments during that time. In order to assist this group of people the provider had altered its surgery hours and provided an evening surgery once a week. This meant that this group of people were able to attend at the practice after their normal working day as well as times during office hours, this provided them with extra flexibility to attend appointments at the practice.

People in vulnerable circumstances who may have poor access to primary care
Patients with sensory impairment were able to communicate with the staff through the use of a hearing loop and larger print pamphlets could be made available if required. For each appointment the reception staff would alert the GP to any particular needs of the patient by putting an alert on the computer. Leaflets giving advice in many different languages were available on their website and interpreters could be contacted for patients whose first language was not English.

Summary of findings

People experiencing poor mental health

The reception staff were aware of patients suffering from poor mental health as alerts were made on the computer system. Flexible appointments were available for people experiencing poor mental health, for example, if patients did not arrive at their scheduled appointment time they would not be turned away but fitted in to see a GP. Staff said that if they saw a patient was distressed and may be in a mental health crisis they would call for a GP to attend and may take them to a quiet room. If they observed deterioration in the mental abilities of a patient they would bring this to the attention of the patient's named GP. The practice supported people with mental health problems by ensuring that staff were aware of the Mental Capacity Act 2005, followed the required processes and, if necessary, made decisions in a patient's best interest.

Summary of findings

What people who use the service say

We spoke with nine patients during our visit, and a further nine patients provided written feedback through comments cards left at the practice for us. The feedback we received from patients was mainly positive. We were told the practice was always clean, comfortable and the environment was safe.

Patients told us the staff had a caring attitude towards them and they were treated with respect and their confidentially was protected.

Patients told us they felt well informed about their care and treatment during consultations and were involved in the decisions about their care. They told us appointments were easy to make. We were also told emergency appointments were available on the same day.

Patients were encouraged to give their views on how the practice was performing through a patient participation group. [PPG] This group would be contacted and asked questions to identify areas on how the practice could improve.

Areas for improvement

Ashburton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a second CQC Inspector, a GP specialist advisor, a practice manager specialist advisor and an expert by experience (a person with experience as a patient or carer).

Background to Ashburton Surgery

The Ashburton Surgery is located at 1 Eastern Road, Ashburton, Newton Abbot, Devon,TQ13 7AP. The practice provides patients with health advice and treatment as well as referral to other care agencies where necessary. The practice is open from 8:30am until 6pm Monday to Friday. A late evening surgery is available one evening a week for patients that find it difficult to visit the GP, nurse practitioner and nurse during the day. At weekends and when the surgery is closed, patients are directed to an Out of Hours service delivered by another provider.

The practice has five GPs, a nurse practitioner, a practice nurse, an assistant nurse practitioner and three phlebotomists (a person qualified to take blood). The GPs and nursing staff are supported by a team of administrative staff. They look after more than 6,000 patients in a rural area.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

Before visiting to inspect the practice, we reviewed a range of information we hold about the service and asked other organisations, such as the local clinical commissioning group, Local Healthwatch and NHS England to share what they knew about the practice. We carried out an announced visit on 10 July 2014. During our visit we spoke with five GPs, the practice manager, a registered nurse, administrative and reception staff. We also spoke with nine patients who used the practice. We observed how patients were being cared for and reviewed comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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:

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

Detailed findings

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

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Are services safe?

Our findings

Systems were in place to recognise and support patients who were at risk of abuse. Staff were trained to work with vulnerable adults and children. There was appropriate equipment, medicines and procedures for managing patient emergencies. Staff were aware of policies and procedures for reporting serious events, accidents, errors, complaints, and for safeguarding patients at risk of harm. Incidents were investigated and acted on, and learning was shared with staff.

Staff were aware of their roles and responsibilities regarding infection prevention and control and effective systems were in place.

Safe patient care

Systems were in place to confirm that all GPs and nursing staff were aware of risks within the practice. An accident and incident book was available and staff were aware of how to report incidents. Senior members of staff were responsible for reviewing complaints and taking the appropriate remedial actions.

A staff noticeboard gave details about the local safeguarding processes, including a website and telephone number for reporting concerns. Staff we spoke with were able to tell us who they would contact if they saw or became aware of a safeguarding issue.

The nurses' treatment rooms and the GPs consulting rooms were visibly clean and infection prevention control procedures were in place.

The GP told us that when they received medical alerts about drug safety they searched their patient records to check whether any patients would be affected, and they took appropriate actions to protect patients. The lead GP also shared medical alert information with other GPs and nursing staff in the practice.

The practice offered a chaperone service. A chaperone is a member of staff who acts as a witness for a GP, nurse and a patient during a medical examination or treatment. Patients also told us they could take someone, for example, a family member or friend, in with them.

Learning from incidents

Systems were in place to identify and prevent risk. The significant event analysis records had been fully completed with action plans and identified the staff who were accountable for ensuring actions were implemented. The practice held regular significant event analysis meetings to ensure that learning was shared. Members of staff gave us an example of learning, for example, how the completing of correct forms was important as not to delay treatment being given.

Safeguarding

All staff had received an appropriate level of training for protecting vulnerable children and adults. The practice safeguarding policies and flow charts displayed in the office and surgeries provided guidance to staff on how to raise safeguarding concerns. We spoke with staff about identifying and preventing abuse. They understood the different types of abuse and were able to describe the procedure to be followed if they suspected or witnessed any concerns. All staff said they would raise their concerns with the GP safeguarding lead. The practice provided safeguarding information notices for patients in the waiting room about how to respond to concerns involving abuse.

We were told the practice kept records of vulnerable patients on their individual files. These alerts were also cross referenced in other family member's records enabling staff to be aware of any issues when they attended the practice for an appointment.

The GP who took the lead for safeguarding children and adults told us they had used the safeguarding process. They gave us two examples where the practice staff had identified possible abuse and safeguarding strategy and case conference meetings had been arranged with social workers, community matrons and themselves to discuss the concerns raised.

Monitoring safety and responding to risk

There were arrangements in place to deal with emergencies. Emergency medicines were available along with oxygen and an automated defibrillator (AED) with ventilation (breathing) equipment for adults and children. Additional oxygen was available on the first floor. The staff had undergone emergency support training so that they could provide assistance with resuscitation until further help arrived.

The practice had procedures in place to identify and respond to risks. There was a business continuity plan that had been regularly reviewed and updated. There was a

Are services safe?

flow chart of contacts for staff to follow along with emergency telephone numbers. Plans were in place to continue to provide a service to patients in the event of the practice premises becoming unavailable.

The practice had undertaken fire drills, completed a fire risk assessment and there was a maintenance contract in place for fire extinguishing equipment. Staff we spoke with were aware of how to respond in the event of a fire.

We spoke with staff about maintenance of the premises. There were contracts in place to maintain heating, electrical and water systems. Any safety concerns or maintenance requirements were reviewed by the lead GP and practice manager.

Medicines management

Ashburton surgery is a dispensing practice. We looked at the procedures for storage and safe dispensing of medicines. Computerised systems and a scanning device were in place to ensure that medicines were in date. The practice only stored limited stocks of regular items and new supplies could be ordered twice a day.

There was a clear audit trail for the authorisation and review of repeat prescriptions. Alerts were raised when the GP was required to review the medicines or if the patient requested medicines early. Any changes to the patient's medicines were flagged on the computer system.

Controlled drugs were stored correctly with only relevant staff having access. We looked at the controlled drugs (CD) book and saw that correct procedures were in place for storage and administration.

All staff working in the dispensary had completed accredited training. The GP lead for the dispensary or the practice manager audited the staff competencies.

The practice had a GP who was the lead for medicines management. Refrigerators were available for the storage of vaccines. The nurse checked and recorded the temperatures twice daily. They told us that any abnormal readings would be reported to the practice manager for action to be taken. This demonstrated the staff recognised the importance of storing vaccines at the correct temperature.

The practice had one visit bag that contained medicines and controlled drugs as only one GP undertook home visits. These were managed by the dispensing staff, including the monitoring of expiry dates and the replacement of used items generated by a GP issuing a prescription for replacement.

For security purposes prescription pads were not stored in the GP consulting rooms, GPs could print a named prescription from their computer system if a hand written item was required.

Cleanliness and infection control

The practice nurse was the lead for the prevention of infection control. There were policies and procedures in place and regular infection control audits were undertaken. On our visit to the practice we inspected the building and looked at areas where care and treatment were delivered.

The treatment rooms used by the nurses had new washable flooring and there were sinks for hand washing with a supply of hand wash and paper towels. There was a supply of disposable gloves and aprons with foot operated waste bins. All surfaces could be thoroughly cleaned and we were told that this procedure was carried out after each surgery. Each of the examination beds had disposable paper covers that were changed after every use. Disposable curtains were used for privacy and we saw that these were clean and last changed in May 2014. A treatment room was used by the phlebotomist, this room was equipped with a sink for hand washing with a supply of soap and paper towels and a pedal operated bin for waste products.

The GP consultation rooms each had an examination couch with disposable curtains that were used for privacy and protective paper covering for preventing the spread of infection. Each had a separate hand washing sink with soap dispenser and paper towels. We were told by the nurses that the GPs were responsible for their own consultation room cleanliness. The rooms we looked at were visibly clean.

Dedicated sharps boxes were available in all the treatment rooms and were used appropriately. A contract was in place for the collection and safe disposal of clinical waste. There were systems in place to manage clinical waste.

Staffing and recruitment

Recruitment and selection procedures were in place to appoint the right staff for the vacant post. Checks included

references from previous employers, details about the candidates training and employment history and proof of identity. Criminal record checks were undertaken for all staff via the Disclosure and Barring Service.

Dealing with Emergencies

The practice had a contingency plan in place to deal with emergencies. The written plan included information on how to manage loss of computer systems, telephone systems, failure of services such as gas and electricity and what to do if any staff were unable to work. It also included details of organisations to contact if any of this happened, meaning that disruptions to patients could be minimised.

Equipment

Fire alarms and equipment was tested and serviced on an annual basis. Records demonstrated that staff had received training in fire safety. First aid kits and emergency equipment were in good order and stored appropriately where they could be reached easily in an emergency.

The practice had systems in place to monitor the safety and effectiveness of equipment. Checks were performed on oxygen cylinders and the defibrillator. All portable appliance testing, water safety, fire safety, lift maintenance and other equipment checks had been undertaken with appropriate certification and validation checks in place.

Are services effective?

(for example, treatment is effective)

Our findings

Patient care was delivered in line with best practice. Systems were in place to ensure the service was monitored and ways for improving the service for patients were explored. Systems were in place for recruiting new staff. The practice worked with other healthcare providers to ensure patients received effective care. Patients were offered advice, treatment and support for their health.

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured staff kept up to date with new guidance, legislation and regulations. The lead GP explained how they kept abreast of updated guidelines and standards and disseminated this information to staff within the practice. GPs and nurses followed the relevant National Institute for Health and Care Excellence (NICE) guidelines for long term condition management. Staff were confident in implementing the Mental Capacity Act 2005 (MCA). The MCA is a framework that supports people who need help to make decisions about their care.

Management, monitoring and improving outcomes for people

The senior partner was responsible for the Quality and Outcomes Framework (QOF). QOF is a means of measuring, collecting and monitoring information to meet nationally recognised standards for improving patient care and maintaining quality. The practice achieved high results in all the domains that ensured that appropriate health checks were offered to patients. The senior partner met with the practice manager on a regular basis to review progress against these targets. When necessary, individual patients that required health screening and had not attended the practice were identified invited to attend the surgery.

Systems were in place for completing clinical audit cycles. Examples of clinical audits included a review of the travel vaccination service that recommended that a supply of vaccines were kept at the surgery to allow a one stop approach rather than multiple visits for the patient.

Staffing

The practice had comprehensive recruitment and selection policies in place which aimed to ensure patients were supported by suitably skilled, qualified and experienced staff. We looked at staff files, which contained information on pre-employment checks and met recruitment requirements.

Staff told us they had undertaken essential training including basic life support, safeguarding of vulnerable adults and children, and infection control. We saw a selection of training records which showed evidence that mandatory training, such as fire awareness and basic life support was provided.

Continuing professional development and training was available for clinical staff. Training was identified from staff appraisals and linked to personal development plans. Staff we spoke with told us about the training they had undertaken. One nurse told us they had completed a diploma in chronic obstructive pulmonary disease (lung disease), which had enabled them to run the specialist clinic at the practice. Another nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council.

Working with other services

The GPs worked with other healthcare providers to ensure that patients received effective care. We were given examples of when multidisciplinary meetings had been held, such as the involvement of the mental health team when assessing a patient's capacity to give consent, and working with the primary health care community nurses to look at ways of reducing the numbers of patients being admitted to hospital with breathing complaints.

GPs discussed the needs of palliative care patients with the community nurses and staff from a local hospice on a monthly basis.

There were also links with the local safeguarding teams for adults and children; this promoted understanding of roles and communication.

Health, promotion and prevention

Information about health promotion and prevention was readily available to patients in the form of pamphlets, large print notices and printed sheets in the reception area, around the waiting room and corridors, and on the practice website. These included information on how to recognise signs of illness, or how to help prevent illness.

Are services effective?

(for example, treatment is effective)

The practice offered clinics for patients with diabetes, respiratory problems and other conditions where health promotion discussions were part of the treatment plan. Screening clinics were held for conditions such as the early detection of diabetes and high blood pressure.

New patients registering at the practice completed a registration form that gathered comprehensive details of their health and lifestyle choices. All new patients were offered an appointment either in person or over the phone. The lead GP told us they used the registration form and initial appointment to identify patients who were at risk or required specific support with a long term condition.

Are services caring?

Our findings

Patients described the staff as helpful and friendly. The receptionists had a warm and friendly approach to patients and visitors. They knew and understood the needs of patients who attended the practice regularly and their approach was kind. Patients told us they were involved in decisions about their treatment.

Respect, dignity, compassion and empathy

We spoke with nine patients on the day of our visit who gave us complimentary comments about the practice. Patients told us the reception staff were always nice and helpful and made them feel valued. They also told us their privacy was respected during consultations. We observed that the receptionists had a warm and friendly approach to patients and visitors; they worked hard to find the earliest appointment to suit the patient.

Steps were taken to communicate with patients living with sensory loss. A loop system was used for patients with hearing loss and large print leaflets were used for patients with sight impairments. Interpreters could be used for patients who needed support with understanding English.

The staff showed knowledge of their responsibilities towards maintaining patient confidentiality. We were given examples to show how confidentially was managed at the practice, which included not leaving test samples visible to other patients and checking that letters to patients were correctly addressed. The environment was adapted so that telephone conversations were not overhead in the reception area, respecting patient's confidentiality.

Involvement in decisions and consent

Patients told us they were involved in the decisions about their treatment. Patients we spoke with told us the GPs explained the treatment and fully involved them in the process. They told us that they were always asked for their consent before treatment was given. There were diagrams on consulting room walls, as well models of limbs that GPs could use to visually demonstrate what the problem was, to help patients make informed decisions.

We saw leaflets giving information on a range of medical conditions in the waiting area. The practice website contained information and guidance about how patients could treat themselves for minor ailments at home.

We asked staff how they managed when patients arrived who did not understand English. Staff told us that interpreters could be contacted for patients requiring this service. The practice also had leaflets giving advice in many different languages available on their website.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Patients were able to access the care they needed promptly and efficiently. The practice had systems to enable patients' views to be listened to and acted on. Arrangements were in place to help the practice meet the demand and needs of patients with minimal delay. Staff told us they had access to appropriate equipment to attend to patient needs. Staff were aware of arrangements for responding to medical emergencies. The practice was accessible to patients with mobility difficulties and those with young children.

Responding to and meeting people's needs

A GP partner told us patient care was key to the values of the practice. We were told weekly practice meetings were held to discuss treatment plans to improve patient care. Patients had access to screening services to detect and monitor the symptoms of certain long-term conditions such as heart disease and diabetes.

Facilities and equipment were designed to help patients access the practice. We saw there was level access into the practice. For patients using wheelchairs the staff would go into the waiting room so they were able to engage with the patients at eye level.

Patients told us that they received text messages from the practice to remind them they were due to attend an appointment. We heard staff confirming with people that the mobile phone details they held for them were accurate.

Patients we spoke with were satisfied with the service they received. They told us that the staff always tried to do their best. The practice had systems in place to listen to patients' views and act upon them. An example being, some patients indicated that it was difficult to obtain an appointment in the evening. The practice adjusted their times and nurse appointments are now also available. The annual patient survey conducted by the patient participation group indicated that they were satisfied with the services provided by the practice.

The receptionists told us that a hearing loop was available for patients with hearing difficulties and a translation service was available for patients who speak a language other than English if required.

Access to the service

The practice operated an appointment system where the majority of appointments were booked on the day either by telephone or in person at the reception. Appointments for routine ailments could be made up to two weeks in advance. The practice kept times available at each surgery for patients who needed to see a GP urgently. An evening surgery was available once a week for patients who found it difficult to attend during usual working hours.

When the practice was closed arrangements about how to get assistance were advertised on the practice website and displayed in the reception area. Recorded messages were left on the practice telephone answering service telling patients who to contact in the event of an emergency, so patients had access to a healthcare advice at all times of the day and night.

The practice told us the GPs often conducted home visits for patients who required them and also visited patients in a local nursing home. This meant that patients who found it difficult to leave their home were provided with consultation, care and treatment.

Concerns and complaints

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

The complaints policy was displayed in the reception area. The practice had responded to complaints in a timely way. There had been several formal complaints, these had been addressed in line with the practice's complaints procedures. All complaints were reviewed and discussed annually in a team meeting of all staff and learning points had been identified. For example, for patients with complex care needs a note was placed on their records to identify which GP they needed to see to ensure continuity of care.

We spoke with patients about making a complaint. Patients told us they did not have a need to make a complaint but would talk to the practice manager and be confident that it would be resolved.

Are services well-led?

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

Our findings

A leadership structure and processes were in place to keep staff informed of any changes. The GPs and practice manager regularly reviewed complaints and significant events, to maintain and improve patient care. Staff felt valued and well supported. They were able to give their views on any improvements. The practice had responded to patients' views and patients gave positive feedback about the care provided.

Leadership and culture

The practice had a leadership structure in place and a written mission statement that specified the aim of achieving a professional, caring, and friendly service. There were regular meetings with all staff within the practice and planned training events to achieve this. All staff we spoke with were very satisfied with the working environment and the support they received from their colleagues and felt that they could contribute to continually improving the practice.

Senior GPs provided support to the trainee GPs and held regular meetings to discuss decisions made and treatments prescribed. Staff we spoke to understood their roles and responsibilities at the practice.

Governance arrangements

Staff told us there were good working relationships; they were involved in practice strategy and future plans. The GP partner team were allocated particular responsibilities. For example, partners were assigned to key areas, which included safeguarding and prescribing. The practice manager was able to demonstrate the use of data, audits and benchmarking information on how risks were minimised. Decisions about the practice were made through GP partner meetings. Multi-disciplinary meetings were held monthly and included clinical governance and clinical management.

Policies and procedures were in place to guide the staff on making decisions and achieving outcomes for patients. The range of procedures were accessible to staff and included chaperone, confidentiality, and infection control. Staff were aware of Gillick competence principles (by which patients aged 16 and under may be able to consent to medical treatment, for example contraception, without the need for parental permission or knowledge).

Partner GPs were involved in training and supporting trainee GPs and medical students. The GPs were responsible for decisions in relation to the provision, safety and quality of care and worked with the practice managers to ensure identified risks were acted upon. GPs engaged with the local clinical commissioning group to discuss new pathways for care.

Systems to monitor and improve quality and improvement

The practice used available data, for example from the Quality and Outcomes Framework, to identify areas for improvement. For example, staff found the practice had a higher than average hospital admissions for people suffering with breathing difficulties. Staff investigated the reasons for this and contacted each patient to enquire whether any additional support from the practice or the primary health care team was required. They found, for example, the need of further education on the use of medicines.

A GP was the lead for education at the practice and made arrangements for the trainee GPs. A spread sheet demonstrated GPs, nurses and administration staff had completed a range of training in relation to their role. Staff told us that they had educational meetings on a regular basis where speakers would come to the surgery. The nurses undertook training to remain up to date with topics that were relevant to their jobs, for example training in respiratory diseases and diabetes.

We saw records demonstrating that staff had an individual appraisal carried out by their manager. The nursing staff received their performance appraisal from a GP at the practice. Staff told us that they felt valued and supported with their training needs.

Patient experience and involvement

The practice had a patient participation group (PPG). A PPG is a group of patients registered with the practice who have an interest in the services provided. The aim of the PPG is to represent patient views, to work in partnership with the practice, and to improve the services patients receive. We spoke with the coordinator of the PPG who told us they were proactive in trying to recruit new members but there was little uptake. There were invitations to join the patient participation group and information about its work displayed in the reception area and on the practice

Are services well-led?

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

website. The group was involved in agreeing the questions for the annual patient survey and reviewing the resulting action plans. Following the last survey more detail on how to obtain test results was added to the practice website.

Staff engagement and involvement

Staff told us there was excellent communication with the whole staff team. The staff understood the need to recognise and act on the views of patients and their carers. Whistleblowing policies and procedures informed staff that they were expected to report poor practice by other staff. Staff knew they could direct their concerns to any member of the leadership team. Team meetings were organised at all levels where discussion about the quality of services to patients was reviewed.

Learning and improvement

The practice continuously strived to learn and improve to provide high quality care. There was evidence of recognised and appropriate meetings within the practice including GP partner, whole staff team, and GP and nursing staff meetings. Documentation confirmed that performance management and appraisal were routinely undertaken for all staff. This meant patients received care and treatment from staff who were supervised, deemed competent and qualified to meet their needs. Training on relevant subjects was also included as part of the regular staff meetings.

Identification and management of risk

The practice had a system to evaluate patient complaints and significant clinical events. Risk assessments were undertaken to identify the risks to patients and staff. We saw a range of risk assessments, which included infection control and fire.

Where possible risks were identified, detailed protocols were developed to describe the actions to be taken. For example, we saw written guidance for actions to be taken in the event of electric failure which included arrangements for vaccines being stored in fridges, loss of IT services and the telephone systems.

A separate building with rooms and facilities had been identified for continuing treatment to patients in the event of the practice not being able to be used through flood for example.

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

Nursing staff were trained in the treatment of physical conditions that affected older people. The practice regularly held meetings with other agencies to discuss patient cases where end of life care needed to be considered. These meetings were held monthly and were attended by health visitors, hospice staff and community nurses. The cases discussed were mainly about elderly patients, but not exclusively so.

The practice had close working relationships with the community nursing team. Staff told us they received regular updates from the community nurses regarding care of elderly patients in their own homes.

The practice looked after patients in rural villages with limited public transport. The practice supported a charitable organisation that provided transport for patients to attend the practice. GPs would make a home visit when a patient was unable to travel. Flu vaccinations were offered to older people either in the practice or in the patient's own home and the practice has had a good response and uptake.

The practice had a lead nurse for palliative care, they held regular meetings and worked closely with the community matron and complex care team so that the patient received the best possible end of life care.

Ashburton Surgery are in the process of ensuring that patients over 75 years of age are given a named GP to ensure continuity of care.

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

The practice supported patients with long-term conditions such as respiratory disease and diabetes by offering screening, treatment and information. Regular monthly clinics were held for patients with long-term conditions.

Specialist nurses supported patients with long term conditions such as diabetes and respiratory disease by offering them advice, education and treatment through specialist clinics.

People with long term illnesses were identified on the practice's computer systems and their medical cases were reviewed annually.

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

The practice supported mothers, babies, children and young people by working with other healthcare providers to provide maternity services and young children clinics. Students were able to attend a contraceptive clinic during the lunch time.

Community midwives and health visitors attended the practice on two days of the week. They worked with the GPs and the practice nurses to provide pre and post natal care for mothers and for babies in the first 28 days of life.

A health visitor was available for babies and young children. They monitored child development, promoted family and public health, offered advice on immunisation and ran a weekly child health clinic, when a GP was also available for advice.

The practice provided inoculation against disease to babies and children under the age of five years.

Staff told us that safeguarding children and adults was important to the practice. There was a safeguarding lead. Staff knew the types of abuse, and the actions they needed to take if they suspected abuse. Information about patients identified to be at risk, or families with concerns was reviewed and discussed confidentially with the health visitor at practice meetings.

Students were offered a lunchtime contraceptive clinic at the surgery.

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

The practice had recognised that people who worked during normal office hours sometimes found it difficult to attend for appointments during that time. In order to assist this group of people the provider had altered its surgery hours and provided an evening surgery once a week. This meant that this group of people were able to attend at the practice after their normal working day as well as times during office hours, this provided them with extra flexibility to attend appointments at the practice.

The practice supported the working age population and those recently retired by providing screening for common conditions. Regular blood pressure monitoring and health screening was available to promote early detection of illness or disease.

They offered a flexible appointment system and access to information and services, such as being able to order repeat prescriptions via the internet. The practice had extended opening hours in the evening one day a week.

Patients could take advantage of telephone consultations with either the GP or practice nurse.

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

People with a learning disability were encouraged to attend the practice for appointments. If they were unable to do so the GP attended their home to carry out physical health checks.

For families where English was not their first language the practice provided a translation service and pamphlets. Patients with sensory impairment were able to communicate with the staff through the use of a hearing loop and larger print pamphlets could be made available if required. For each appointment the reception staff would alert their GP to any particular needs of the patient by putting an alert on the computer.

We asked the practice whether they would be able to arrange an appointment for a patient who had no local home address. Staff told us that they had a lot of holiday makers who visited the practice for immediate treatment. They would ask the duty GP to see them and would complete the temporary resident form.

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

The reception staff were aware of patients suffering from poor mental health as a flagging system was used on the computer system to alert staff. Flexible appointments were available for people experiencing poor mental health, for example, if patients did not arrive at their scheduled appointment time, they would not be turned away but fitted in to see a GP.

The practice staff had formed valuable relationships with the local community mental health team.

The reception staff said that if they saw a patient was distressed and may be in a mental health crisis they would call for a GP to attend and may take them to a quiet room. If they observed a change or deterioration in the mental abilities of a patient they would bring this to the attention of the patient's named GP.