Castle Gardens Surgery

Quality Report

Castle Gardens Gardens
Torrington
Devon
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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?	Outstanding
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

Castle Gardens Surgery was inspected on Monday 13 October 2014. This was a comprehensive inspection.

Castle Gardens Surgery provides primary medical services to people living in the town of Great Torrington and surrounding villages in Devon covering approximately 100 square miles. The practice provides services to a diverse population. At the time of our inspection there were approximately 6,600 patients registered at the service with a team of five GP partners.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice is rated as good . Our key findings were as follows:

- Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients.
- The practice valued feedback from patients and acted upon this. Feedback from patients about their care and treatment was consistently positive. The culture of the practice was patient centred. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were very positive and were aligned with our findings.
- The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

Summary of findings

- Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's mental capacity to make an informed decision about their care and treatment, and the promotion of good health.
- Information received about the practice prior to and during the inspection demonstrated the practice performed comparatively and in some instances better when compared with all other practices within the clinical commissioning group (CCG) area.
- Patients told us they felt safe, that staff were professional and they felt confident in clinical decisions made. There were effective safeguarding procedures in place.
- Significant events, complaints and incidents were investigated and discussed. Staff learned from these events and shared their learning within the team, although the written evidence for this process did not always consistently show what learning and actions had taken place following such investigations.

We saw areas of outstanding practice including:

- The practice was responsive and innovative in the way it engaged with people with learning disabilities with complex communication needs. For example, staff responsible for annual health checks had made several out of hours visits to a care home where these patients lived. Information for patients was in an easy read format so they were fully involved in making decisions about their health. This meant patients were able to get to know the staff from the practice in a place where they felt at ease. At the same time, practice staff learnt from care home staff how best to meet the complex communication needs of each patient, which was then put in place at Castle Gardens Surgery. Important screening was carried out successfully, which included blood tests and cervical smears to manage ongoing health, because of the time taken to prepare patients and reduce their anxieties.

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

Importantly, the provider must:

- Keep dispensed high risk medication and stamped prescription pads secure at all times.

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 care, as there are areas where improvements should be made.

Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated to support improvement. However, there was no system for ensuring the changes to practice were embedded and sustained. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough. We identified risks with regard to the security medicines. The practice managed the complex needs of patients well and responded in a timely way when urgent care and treatment was required.

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. National Institute for Clinical Excellence (NICE) guidance were referenced and used routinely. Patient needs were assessed and care planned and delivered in line with current legislation. This included assessment of patients capacity to give informed consent and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. Multidisciplinary working was evident to manage risks and improve patient experience.

Are services caring?

Outstanding

The practice was rated as outstanding for providing caring services.

Data showed patients rated the practice higher than others for some aspects of care. Fifty eight CQC comments cards reviewed and discussion with eight patients on the day all provided positive feedback. A common theme was that the staff were extremely person-centred and patients were always treated with respect and compassion. This was borne out in the way staff engaged with patients with complex communication needs.

Staff we spoke with were aware of the importance of providing patients with privacy. Information was available to help patients understand the care available to them.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services.

Summary of findings

Patients reported good access to appointments and a named GP and continuity of care. Urgent appointments were available the same day. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with staff and other stakeholders. Improvements as a result of the learning from complaints included increased staff hours which extended access to blood screening for working people.

Are services well-led?

Good

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

The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). 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

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

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The frailty of some patients was recognised and the practice held a list of patients in this position and those receiving end of life care. The list of patients was closely monitored every month with other health and social care professionals supporting the patient. The practice responded quickly to potential risks for patients and helped organise additional support so that unplanned admissions to hospital were avoided where ever possible.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

Emergency processes were in place and referrals were made for patients in this group who had a sudden deterioration in health. Longer appointments and home visits were available if needed. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Three patients with long term conditions explained they had a care plan in place, which set out potential risks and early interventions to prevent their health from deteriorating. For example, one patient described how their lung capacity was closely monitored and was attending the practice at part of the plan as they were feeling unwell that day.

Families, children and young people

Good

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

Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk,for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all

Summary of findings

standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. For example, a parent described their confidence in the GPs diagnosis when their baby became acutely ill and required immediate transfer to hospital by emergency services. A female patient told us their GP had recorded on their records that there was a family history of ectopic pregnancies. When they themselves started to experience complications early in their pregnancy they said they felt safe because the GP immediately diagnosed a problem, which required immediate referral for urgent hospital treatment.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Working patients had access to late appointments every Monday evening and GPs offered other times by arrangement. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the population group of people living in vulnerable circumstances.

The practice had recognised the needs of different groups in the planning it's services and provided a responsive service. For example, the practice was promoting equality in the way it supported 22 patients with a learning disability. Named staff had received additional training and worked closely with community specialists supporting people with learning disabilities. An example of outstanding practice was the way the practice communicated and developed trusting relationships with patients with learning disabilities who had complex communication needs. The practice was innovative in this and staff responsible for annual health checks had made several out of hours visits to a care home where these patients lived. Information for patients was in an easy read format so

they were fully involved in making decisions about their health. This meant patients were able to get to know the staff from the practice in a place where they felt at ease. At the same time, practice staff learnt from care home staff how best to meet the complex communication needs of each patient, which was then put in place at Castle Gardens Surgery. Longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. Important screening was carried out successfully, which included blood tests and cervical smears to manage ongoing health, because of the time taken to prepare patients and reduce their anxieties. Data showed 100% of patients with a learning disability had their health care reviewed in the last 12 months.

All new patients registering with the practice were treated equally and with dignity. For example whilst there were no homeless patients registered at the practice, systems were flexible so that should a new patient in this situation wish to register they could do so. Staff took a holistic approach with patients and recognised the importance of using every contact with a person to carry out health checks so that any issues were identified and treatment commenced.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The level of health checks and support people experienced exceeded national averages. 96% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning and 99% patients with dementia had been reviewed in consultation with their GP face to face in the previous 12 months. A carer who looked after a relative with dementia told us their GP had responded quickly when their relative's health had deteriorated and they had reached crisis point.

Summary of findings

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Patients experiencing a mental health crisis were well supported. This included supporting them to access emergency care and treatment. For example, staff told us they worked closely with the local Crisis Resolution and Home Treatment Team (CRHT) to support patients experiencing mental health crisis.

The practice monitored repeat prescribing for patients receiving medication for mental health needs. For example, some patients attended the practice to be given depot medication. Staff explained that if patients failed to attend for these appointments they knew this could be a sign that the patient's mental health was deteriorating. They then followed procedure and contacted the community mental health team for assistance to check the patient's mental well-being.

Summary of findings

What people who use the service say

The 2014 national GP survey results for Castle Gardens Surgery based on 218 (3% of patients on the practice list) responses were better in all areas compared to the clinical commissioning group (CCG) and national average. The results of the practice participation group (PPG) survey 2014 based on 218 responses indicated patients were also very positive about the care they received.

During the inspection, we spoke with eight patients, two of whom were also representatives of the patient participation group (PPG).

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 experiences with us. We collected 58 comment cards, which contained detailed positive feedback about Castle Gardens Surgery.

The overarching theme from patients in their responses was that they were grateful for the caring attitude of the staff who took time to listen. Staff were described by patients as being kind, compassionate and responsive when they saw them. Patients were confident about the advice given and medical knowledge of their GPs. Access to appointments and the length of time given was described as a high point by patients who told us they never felt rushed. Patients were positive about the continuity of care they received from the team. Some patients were also carers and told us they received excellent support, which helped them care for their loved ones.

These findings were reflected during our conversations with patients and discussion with the PPG members. All of the patients gave positive feedback. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were excellent and thorough when it came to diagnosis and treatment.

Parents told us the staff treated their children with respect. We were told the staff were good at communicating with children and young people, which in turn helped reduce any anxieties they might have had about visiting the practice.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients felt listened to and told us they had no complaints. They showed us information about how to make complaints, which was clearly displayed and told us they were confident that if they did have any concerns they would be acted upon.

Patients were satisfied with the facilities at the practice. The building was highlighted as being accessible for people using mobility aids, safe, clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the website was good.

Areas for improvement

Action the service MUST take to improve

Dispensed high risk medication and stamped prescription pads must be kept secure at all times.

Outstanding practice

The practice was innovative in the way it engaged with people with learning disabilities with complex

communication needs. For example, staff responsible for annual health checks had made several out of hours visits

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to a care home where these patients lived. Information for patients was in an easy read format so they were fully involved in making decisions about their health. This meant patients were able to get to know the staff from the practice in a place where they felt at ease. At the same time, practice staff learnt from care home staff how best to meet the complex communication needs of each patient, which was then put in place at Castle Gardens Surgery. Important screening was carried out successfully, which included blood tests and cervical smears to manage ongoing health, because of the time taken to prepare patients and reduce their anxieties.

Castle Gardens Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC lead inspector.** The team included a GP, a CQC pharmacist inspector, a practice manager and an expert by experience.

Background to Castle Gardens Surgery

Castle Gardens Surgery is a GP practice providing NHS primary care services for approximately 6,660 patients. Of these patients there are lower percentages of children, young people and working age people under 50 years of age in comparison to other local services. The percentage of patients over 75 years of age is higher than the national average. The practice has a total of seven GPs who are supported by three qualified nurses and two healthcare assistants, comprising of two male and 10 female staff. There is an administrative team consisting of a practice manager and receptionists. Opening hours are between 8am to 1.15pm and 2pm to 6pm Monday to Friday. The practice provides extended opening hours every Monday from 6.30pm to 7.45pm. There is a dispensary at the practice, which is open for ordering and collection of medicines from 8.30am to 12pm and from 3pm to 6pm. Patients are also able to collect medicines from reception between 12pm and 3pm. Emergency Out of Hours cover is delivered by another provider.

Castle Gardens Surgery has one location at Castle Hill Gardens, Torrington, Devon EX38 8EU. We carried out our announced inspection at the practice on Monday 13 October 2014.

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 was 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.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included information from NHS England, NEW Devon CCG, Devon Healthwatch and the local council Health and Scrutiny Board. We looked at the 2014 NHS patient survey and corresponding action plan the practice had in place. We carried out an announced inspection on 13 October 2014. During our visit we spoke with staff (GPs, nurses, healthcare assistants, managers and administrative staff). We spoke with eight patients who used the service, two of whom were representatives from the patient participation group (PPG). We observed how patients were being cared for and talked with carers and/or

Detailed findings

family members and reviewed personal care or treatment records of patients. We reviewed 58 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

At Castle Gardens Surgery there is a higher percentage of patients over 50 years old registered with the practice when compared to national averages. There are fewer children and young people registered with the practice when compared to national averages. The practice covers a 100 mile radius of rural and semi- rural areas, which are less socially deprived.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety,for example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, staff told us about an emergency which had occurred whilst immunising a child. Emergency equipment and guidance had been reviewed and this resulted in clearer labelling of medicines to improve access in the event of an emergency.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last two years. NHS England told us the practice shared serious event audits (SEAs) and serious incidents requiring investigation (SIRIs) with them, so was considered to have a good reporting culture. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were discussed at practice meetings with a dedicated meeting occurring every three months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system used to oversee they were managed and monitored. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, we discussed with staff a significant event where abnormal blood results had not been followed up in a timely way. Records showed this was quickly reported and appropriately investigated.

National patient safety alerts were disseminated by email to practice staff and accessible on the practice intranet. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at daily meetings between doctors and the nursing team to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The team had clear oversight of patients who could be at risk of unplanned admissions to hospital, who were receiving palliative care or had complex care needs. Minutes of monthly meetings were seen, demonstrating that the team worked in close collaboration with other health and social care professionals to manage and review the risks for vulnerable patients.

Training records showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. The practice manager demonstrated that they had taken action to address gaps in training, for example it was identified that one member of staff had not completed training and this was arranged. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible to all staff at the practice.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children. They had been trained to level 3 to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Two examples were discussed with the safeguarding GP lead and lead nurse, both of which demonstrated that the practice worked collaboratively with the safeguarding board, parents and other health and

social care professionals to protect the children involved. We were told that GPs had attended child protection meetings and minutes were obtained. Staff explained that patient records flagged up concerning information and highlighted potential risks for vulnerable adults and children using a coded system. The safeguarding lead explained that the practice had identified vulnerable adults and worked closely with other health and social care professionals to protect people. District nurses reported that this system worked well and appropriate additional support was obtained for patients at risk.

A chaperone policy was in place and displayed on the waiting room noticeboard and in consulting rooms. The practice policy highlighted that only nurses and healthcare assistants carried out chaperone duties. Chaperone training had been undertaken by all nursing staff, including health care assistants. The staff understood their responsibilities when acting as chaperones including where to stand to appropriately observe the examination.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system (SystmOne) which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

The practice must improve the way they manage medicines. The practice dispensed medicines for approximately half of the registered patients. There was a refrigerator in the dispensary for any items requiring cold-storage and we saw that there was monitoring of temperatures to ensure these medicines were stored correctly. We were told that there were no regular checks made of expiry dates of stock held in the dispensary, but that these were checked at the time of dispensing. The practice did not monitor the temperature of the dispensary to ensure that all medicines kept were suitable and safe to be used.

Controlled drugs were stored securely and were recorded in a register when received, given out or destroyed. The practice had detailed standard operating procedures for dispensary tasks which provided guidance for staff. However, controlled drugs dispensed for patients were not stored in the safe whilst they were waiting to be collected, which was not in line with these procedures. Systems in place ensured that all dispensed medicines had been prescribed and signed by the doctor before they were prepared or given out to patients. There were arrangements in place for the destruction of controlled drugs.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff. There were systems to record any errors or incidents occurring, so that lessons could be learnt and procedures changed if necessary to reduce the risks in future. We found that there had been no incidents reported in the dispensary over the last two years.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. There were systems in place to ensure that all prescriptions were authorised by the prescriber, and that patient medicines were regularly reviewed. The computer system allowed for highlighting high risk medicines and those that required more detailed monitoring, and for checking for allergies and interactions. Patient records were updated following a patient's hospital discharge or a home visit. Systems were in place to make sure that any changes or updates to patient medicines were always made and authorised by the doctor.

Vaccines were stored appropriately. There were auditing systems in place to ensure that the cold chain was maintained so that these products would be safe and effective to use with patients. However, the thermometer used to carry out these checks was not calibrated regularly providing assurance of the temperatures being monitored. The refrigerator used to store vaccines was not hard wired, which would reduce the potential risk of it being accidently switched off. Other medicines kept at the practice for use by GPs and practice nurses were stored safely and systems were in place to monitor expiry dates. Emergency medicines and equipment were available at the practice. Systems were in place to make sure these were checked regularly. Medicines that were kept in any doctors bags were the responsibility of each GP to maintain supplies and ensure expiry dates were checked. We checked two doctor's bags and found supplies were in date.

Blank prescription forms for printing were stored securely, and serial numbers were recorded on receipt, and when issued to doctors rooms or printers. However, we saw that

some blank prescription forms, pre-printed with the surgery details, were kept in an unlocked drawer in the dispensary. We were also told by dispensary staff that it was not recorded if these were taken by doctors for their bags or surgery rooms. This was not in line with current guidance from NHS Protect on the security of prescription forms. Following the inspection, we received further information from the practice demonstrating that the protocols had been discussed at a practice meeting and reviewed to improve security and included an audit process.

Records of practice meetings noted the actions taken in response to reviews of prescribing data, for example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. In April 2014, the practice had looked at prescribing patterns of medicines used to reduce gastric reflux for patients. This showed the GPs were working within the latest guidelines so patient safety was maintained and with the local area optimisation team to prescribe in a cost effective way.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. Staff told us the administration team held a list of tasks each nurse and healthcare assistant had received training for and were able to undertake. For example, only nurses who were trained to do so carried out baby immunisations.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice had recently carried out a prescribing review of pain relieving medication for patients with complex needs. This showed the team of GPs had worked with patients to reduce the dose they had been prescribed and doses were within safe limit guidelines.

Training records showed that staff working in the dispensary had received appropriate training and regular checks of their competence were completed. The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. An audit was carried out in April 2014 by an external assessor from the local area team, which concluded the dispensary was well run.

Cleanliness & Infection Control

Eight patients we spoke with told us the practice was always clean and tidy and this was borne out by our observations. Fifty eight patients also fed back that they had no concerns about cleanliness or infection control.

The practice had a lead GP 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 induction training about infection control specific to their role and had received an update in May 2014. We saw evidence that nursing staff had carried out monthly audits of treatment areas, providing assurance that deep cleaning of these areas took place. The infection control systems had been audited by an external contractor specialising in infection control who had highlighted areas for improvement, which were actioned. Practice meeting minutes showed the findings of the audits were discussed with staff. For example, the practice needed to ensure that all staff handled urine samples safely to reduce the risk of cross infection. Staff told us that safe handling of specimens had been raised, additional training provided and audits undertaken to ensure urine samples were disposed of safely.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. However, the policies had been written in 2012 and made reference to a washer disinfector being used to sterilise equipment. Nursing staff verified that the practice did not have a washer disinfector and that all equipment, for example airways used to monitor lung function were single use only. Other instruments used for minor surgical procedures were sent to the hospital for sterilisation. Nurses told us they cleaned equipment used to test patients blood pressure and lung capacity after every patient. The lead nurse told us the policies were currently under review.

Policies in place covered areas such as personal protective equipment including disposable gloves, aprons and coverings which were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was a policy for needle stick injury, which linked with occupational support for staff in the event of an injury. Staff told us they had been made aware of the latest guidance about needles and were using safer equipment outlined in this document.

Requires improvement

Are services safe?

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 microbe found in the environment which can contaminate water systems in buildings). Records showed that the practice had been risk assessed by an external contractor in November 2013. Recommendations were made but action plans had not been put in place following the assessment to reduce the risk of infection to staff and patients. Immediately following the inspection, we received further information showing that the recommendations had been actioned.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly for patient use and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example electrical items had been tested by a local electrician in January 2014. Calibration of medical equipment was undertaken by an external contractor and we saw the inspection report and certification for 2014.

Staffing & Recruitment

We looked at five staff records, all of which contained evidence that appropriate recruitment checks had been undertaken prior to employment, for example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only nurses or health care assistants had this additional duty and a DBS had been obtained for all of them.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Two nurses and a healthcare assistant told us they were never expected to work outside of their scope of practice. They shared examples of how their professional competencies linked with health promotion clinics being delivered. For example, a nurse had completed level 3 diabetes management training so was able to initiate insulin use and management for patients. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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 ensure patients were kept safe. Records demonstrated that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

There were systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

- For patients with long term conditions there were emergency processes in place. Staff gave us examples of referrals made for patients that had a sudden deterioration in health. Three patients with long term conditions explained they had a care plan in place, which set out potential risks and early interventions to prevent their health from deteriorating. For example, one patient described how their lung capacity was closely monitored and was attending the practice at part of the plan as they were feeling unwell that day.
- There were emergency processes in place for identifying acutely ill children and young people and staff gave us

examples of referrals made. A parent described their confidence in the GPs diagnosis when their baby became acutely ill and required immediate transfer to hospital by emergency services.

- Emergency processes were in place for acute pregnancy complications. For example, a patient told us that past family history was recorded on their notes, so when they experienced complications urgent treatment was sought for them.
- Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. For example, staff told us they worked closely with the local Crisis Resolution and Home Treatment Team (CRHT) to support patients experiencing mental health crisis. A carer who looked after a relative with dementia told us their GP had responded quickly when their relative's health had deteriorated and they had reached crisis point.
- The practice monitored repeat prescribing for patients receiving medication for mental health needs. For example, some patients attended the practice to be given depot medication. Staff explained that if patients failed to attend for these appointments they knew this could be a sign that the patient's mental health was deteriorating. They then followed procedure and contacted the community mental health team for assistance to check the patient's mental well-being.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff had received training in basic life support. One of the GPs had also developed in-house training for staff in emergency procedures, which all of the staff we spoke with had attended. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient was discussed and appropriate learning had taken place. Some alterations had been made to the labelling of emergency equipment so that it was easier to locate in an emergency situation.

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. Processes were also in place to check 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. Each risk was rated and mitigating 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, we saw the plans included being supported by another practice that was nearby.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. Staff were up to date with fire training. However, no regular fire drills were undertaken which was confirmed by the practice manager. Within 24 hours of the inspection, we received further information from the practice showing that action had been taken to address this issue. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. For example, a full time GP had reduced their working hours to part time. The practice identified a number of risk factors linked with this changed such as the impact on continuity of care for patients due to the increased use of locum GPs. Instead, the practice chose to replace the GPs hours by increasing the hours of a part time salaried GP so that the staffing establishment had capacity to cover annual leave without having to use locum staff. The registered manager and senior GP partner explained this then had a positive impact having increased the length of time patients were able to spend seeing their GP.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, detailed assessments of patients' needs and these were reviewed when appropriate. For example, GPs told us they had recently received and discussed the latest NICE guidelines published in September 2014 about current antidepressant treatment for adults and were prescribing accordingly.

The GPs told us they lead in specialist clinical areas such as emergency medicine, diabetes, heart disease and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. GPs and Nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they met with the nurses to discuss new best practice guidelines at a daily meeting. Clinical meeting minutes confirmed this happened. One of the GPs had developed in-house training for other GPs and nurses covering emergency treatment of patients with suspected cardiac arrest.

The prescribing lead GP partner showed us data from the local CCG of the practice's performance for prescribing pain relief which was comparable to similar practices. The GPs utilised an IT system which provided medicine options for GPs to use when making decisions about prescriptionsfor repeat prescribing, and knew the practice was consistently within budget for medicines. The practice had also completed a review of patient notes to identify those who could be at risk of developing cardio vascular disease. Information systems showed that the percentage of patients recorded at risk was low, however GPs questioned this finding and had sought further advice and increased monitoring was put in place.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with followednational standards and ensured that patients with with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were held, and improvements to practise were shared with all the GPs and nursing staff. For example, information collected by the Clinical Commissioning Group (CCG) had previously shown that the number of patients referred to surgical specialists was higher when compared with other practices. GPs at the practice used this information to look more closely at how referrals were made to ensure they were timely and appropriate. The practice had invited a consultant surgeon to the GPs' educational meetings do discuss referral thresholds for patients so that a consistent approach was taken by the team. At the time of the inspection, the data from the CCG showed that referrals were within national standards.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture at the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making. We met eight patients with diverse needs who all said GPs referred them to specialists without hesitation when a second opinion was required.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and to support the practice to carry out clinical audits.

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 national performance measurement tool. For example we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. 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. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice showed us other audits that had been undertaken in the last year but were not repeating these to show that change was sustained. For example, we looked at an audit of patients who were prescribed anticoagulant medicines. This showed 97% of the patients in the audit had blood test carried out within appropriate timescales to monitor that the dose they were taking was safe for them. The practice had reminded patients about the importance of blood monitoring and showed all of the patients had the next appointment booked for a blood test. There were action points for the GPs, Nurses and Dispensary staff aimed at increasing patient safety and improving written records. For example, GPs were asked to use words to denote doses to reduce the risk of incorrect doses being dispensed to patients. The practice newsletter reminded patients on anticoagulants to refer to information given to them to increase their awareness of treatment, monitoring and potential risks. However, the practice was unable to demonstrate that the changes implemented since the initial audit were embedded in day to day practise six months on.

Nurses were also subject to clinical audit cycles. For example, nurses explained that cervical smears were audited and their competency to practice had to be revalidated every three years to carry these out. Results of smear tests for female patients were always checked by the lead nurse. 'Inadequate' smear test results led to the patient being recalled and additional audits being triggered for the individual nurse who carried out the test. This ensured the cervical screening service was constantly monitored for patients.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 94% of patients with diabetes had an annual medication review, which included screening the patient for known risk factors such as peripheral arterial disease and kidney failure. The practice also met all the minimum standards for QOF regarding asthma, chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF or any other national targets and for some performed better than expected.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of nurses and GPs. The staff group had reflected upon 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. For example, one of the nurses had carried out a wound management audit, which looked at the treatment and healing outcomes for patients with leg ulcers. An audit of patients on the combined contraceptive pill carried out by a GP had identified patients with higher risk factors such as smoking. The information gained was used to target health promotion advice and signpost patients to the smoking cessation programme.

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 patients with 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 prescribed medicines. This showed GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, data showed that GPs at the practice were better than average at reviewing all patients on the palliative care register with other health and social care professionals who might be supporting them in the community.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. All staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors, for example one GP specialised in cardiac care and provided in house training for staff. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

Good

Are services effective?

(for example, treatment is effective)

All of the staff interviewed confirmed that annual appraisals were undertaken. These identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example one of the nurses was in the process of doing a university based foundation course in general practice nursing.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. These duties included immunisation of babies and children, cervical screening and blood taking. All three nurses explained that the administration team had information about their scope of practice which was linked to completed training and assessment of competence. They confirmed that they were never asked to work outside of their professional competence, so worked within safe boundaries when caring for patients. The lead nurse had an extended role in management of patients with long-term conditions such as asthma, chronic pulmonary disease, diabetes and coronary heart disease and had appropriate training to fulfil these roles. For example, the nurse verified they had completed the level 3 course in the management of patients with diabetes, which enabled them to initiate insulin treatment. Another nurse had completed a diploma in respiratory disease management and had chosen to continue to shadow the lead nurse for an extended period of time.

Working with colleagues and other services

Educational meetings run by secondary services were attended by GPs at the practice. For example, GPs had attended meetings with a consultant psychiatrist to increase their understanding about diagnosing dementia for patients and support available in the area. This included making timely referrals for patients to the memory clinic at the local hospital so a definitive diagnosis could be made and followed up with support. We saw information about this in the waiting room. Two carers told us the practice worked closely with a community support worker who supported them and their relatives who had been diagnosed with dementia.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their records. These were used to co-ordinate holistic care for patients receiving palliative care and demonstrated that the team works collaboratively with the local hospice to meet patient needs.

Areas of potential unmet need for patients regarding mental health support in the local area had been escalated to the CCG by the GPs at the practice. For example, access to psychological services for patients had been raised as a concern and potential focus for future service commissioning. To improve access to counselling services for patients with less complex needs, the practice rented accommodation to a practitioner who was providing private counselling services.

The practice used an electronic patient record system, into which results from investigations such as blood testing, letters from consultants and discharge letters from hospital were scanned in. Specific staff oversaw this process each day and created a task within the system for the patient's GP to review the results. There was a buddy system in place for GPs to ensure that patient's results were reviewed and action taken where necessary.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient information to be shared in a secure and timely manner. The practice had a list of patients who were vulnerable, at risk due to long term conditions and those receiving palliative care. A patient with a long term condition explained that the out of hours service had been made aware of their needs because the practice had shared important information when they were unwell. Electronic systems were also in place for making referrals to secondary care services.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency Department. The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information about this system was published on the practice website for patients and clearly explained the circumstances when information would be shared with other health or social care professionals.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff 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.

Consent to care and treatment

All of the staff we met were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. GPs and Nurses we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). One of the patients we spoke with who was a parent confirmed that all of the staff communicated well with their children and ensured they were always present with the child during the appointment.

Patients with learning disabilities 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 (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, the practice showed us that 100% of care plans for patients with a learning disability had been reviewed in last year. The nursing team had not received training about the Mental Capacity Act 2005 but knew about the general principles and put these into practice. For example, easy read cards with pictures were used for patients with a learning disability to ensure they were fully involved in health assessments and planning their care. Staff also worked closely with patient advocates to ensure that decisions made were in the best interest of the person they were treating.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had been followed in 100% of cases.

Health Promotion & Prevention

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

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS health checks to all its patients aged 40-75. A clinic was held once a week and telephone contact was made with patients to encourage their attendance.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all 22 patients were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months. Similar mechanisms of identifying at risk groups were used for patients who had mental health needs and those receiving end of life care. For example, 93% of patients with complex mental health needs had been assessed with regard to lifestyle choices such as alcohol consumption. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake of patients with complex mental health needs was 89% which was better than the national average. 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 annually. There was a named nurse responsible for following-up patients who did not attend screening.

Good

Are services effective?

(for example, treatment is effective)

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 significantly above average for the CCG and there was a clear policy for following up non-attenders by the named practice nurse. In August the practice had carried out a comprehensive risk assessment and set out plans for the 2014 – 15 influenza vaccination campaign in Torrington. This showed the practice used many different approaches to make the public aware of the vaccination programme to increase patient uptake.

Outstanding ☆

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The verbal and written feedback we received from 66 patients in total had common themes about their experiences at the practice. They highly praised all of the staff who work at the practice. Patients talked of staff being professional, friendly, helpful and caring. One patient said staff were second to none and another said staff were excellent and went beyond what was expected of them. Patients told us staff were respectful and polite.

Patients shared examples of their experiences during times of hardship, bereavement and loss and told us the compassion they were shown had helped them through these times. For example, a carer said they had contacted the practice about a matter involving their relative and was satisfied with the response over the telephone. However, they were then surprised by the GP who later arrived at their home to provide additional support for them and appreciated this as they were feeling stressed and had been unable to ask for it directly.

Privacy and dignity were respected. At the reception desk patients observed a respectful distance. We observed interactions between reception staff and patients. These were polite and professional. There was appropriate screening in consultation and treatment rooms. Patients said chaperones had been offered and sheets used to protect dignity during physical examinations.

Care planning and involvement in decisions about care and treatment

The practice participates in the annual national quality and outcomes framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. Information we reviewed from the QOF monitoring, indicated that 97% of patients with a documented care plan had been involved in decisions about the content.

Patients told us they felt involved in the decisions about the care and treatment they received and were able to decline treatment. None of the eight patients we spoke with said they had ever felt rushed whilst seeing the GPs or nurses. All eight patients said they felt the GP really took time to listen and acted on their wishes. For example one patient spoke of how they had refused counselling and another had chosen not to follow a pathway of care but had been supported by the GP to try an alternative.

Patients told us they were asked for their consent before any invasive treatment was provided. A parent confirmed they had been asked to give consent before their child was given immunisations. Another patient said they had signed a form before receiving minor surgery.

We did not speak to any patients whose first language was not English. Staff told us there were facilities to access a telephone and face to face translation service should it be required.

The practice and consulting rooms had level access. We saw patients using walking aids were able to move without any restrictions between the waiting and consultation rooms.

Everyone working at the practice was expected to sign a confidentiality agreement as part of their contract of work. Patients we spoke with were not concerned about confidentiality. They were aware their information sometimes needed to be shared by the GP or nurse with other healthcare professionals. The training matrix showed that staff underwent training on information governance (sharing confidential information).

Patient/carer support to cope emotionally with care and treatment

The GP practice survey information for 2013-14, which we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 96% of respondents to the patients participant group survey were satisfied with the support services to help them manage their treatment and care. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and ensured their health was assessed as well as the demands of caring for their relative

explored with them. The patient participation group had a notice board and were encouraged to include written information available for carers about the various avenues of support that could be accessed.

Staff told us families who had experienced bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful. The practice had an agreement with a local counsellor to use room facilities once a week, which increased access to talking therapies for patients living in Torrington who could pay privately for this.

The practice recognised that some patients, particularly older people, could be at greater risk due to social isolation. We saw a community network board at the entrance into the practice, which advertised opportunities to socialise and get involved in other activities across all of the villages covered by the practice. We spoke with a patient who had recently moved to the area, who told us this information had been incredibly helpful to them to find support and integrate into the community where they lived.

Patients told us the staff did their utmost to give clear explanations and support, which helped to reduce any anxieties they had. For example, a patient with a long term condition told us that their GP had worked closely with them so they understood how they could reduce the risk of being admitted to hospital. This, they told us, had been their greatest anxiety and their GP had listened and helped develop a self-management plan for the patient. They said they had greater control over their health and knew if they felt anxious or low in mood they could speak to their GP at any time and would be reassured. We saw there was seating opposite the reception desk, where patients were encouraged to rest and engaged in conversation with the staff. Interactions were friendly and caring and demonstrated that the staff knew their patients very well. We observed staff booking taxis for older patients and accompanying them out and into the vehicle when it arrived to take the patient home.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice responded to their individual health needs well. They said that preferences, such as to see a doctor of the same sex, were responded to where possible. All of the patients had a named GP. Eight patients we spoke with consistently commented that their GP had an in-depth knowledge about their needs and the needs of their family. Some said that several generations of their family were registered with the practice out of choice because of the friendly and caring approach they experienced. Patients told us that the practice was reliable, particularly at times of crisis or when in urgent need.

Patients said the prescription system was excellent. Some patients used the on line request service, whilst others called in to collect theirs from the dispensary. All patients said the process took a maximum of three days and a system was used to remind patients to come in for health checks before further prescriptions would be issued.

Secondary care referral to hospitals or other health care providers were made promptly. Patients were able to pick their own routine appointment time through a choose and book system. For urgent referrals to other services GPs completed a template, patient services staff processed it and an appointment was booked. As a result people had an appointment, in most cases, before they left the surgery.

The practice had a patient participation group (PPG) to increase the opportunity for patients to influence the service. This group met frequently, was self-directing with the practice manager present to answer any queries and had requested that a GP be present at every meeting to answer any queries. We spoke with two members of the group who gave us examples of about how the practice had responded to requests. For example, both members were carers and spoke about the instigation of carer's health checks and explained that the practice had set up a monthly clinic to enable carers to meet the community support worker. This ensured that carers had access to additional information such as welfare benefits they could apply for as carers.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning it's services. For example, the practice was promoting equality in the way it supported 22 patients with a learning disability. One of the nursing team staff had undertaken additional training to increase their understanding of the specific needs this group of patients might need. Easy read information was used as prompts during annual health checks ensuring that patients with communication difficulties were fully involved in the process. Staff explained that they had met with patients with complex communication needs in the person's home environment several times to build a trusting rapport with them. The patient eventually attended the practice for a thorough annual health check, which had previously been impossible due to the complexity of their needs causing anxiety when faced with unfamiliar places and routines.

The partner GPs were knowledgeable about changes in the local population in terms of ethnicity and diversity of patients registering with the practice. For example, we were told that some patients were of Eastern European, Italian and Polish backgrounds. The practice had access to online and telephone translation services. However, GPs told us that in most instances patients tended to bring a friend or family member with them to help translate.

Equality and diversity training had been completed by all of the nursing and administrative staff via e-learning. Staff we spoke with confirmed they had completed this training in the last twenty four months and that equality and diversity was regularly discussed at appraisals and team events.

Access to the service

Patients were satisfied with the opening hours of the practice, which included extended hours every Monday evening for working patients. GPs were flexible and offered working patients earlier appointments at other times by arrangement. Feedback cards completed by 58 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Eight patients we spoke with told us the appointment system was accessible, available on line, by telephone or bookable in person. On the day of our inspection visit, two patients had arrived at the practice without an appointment and were provided with one.

Patients told us the triage appointment system had taken a while to get used to but worked well. They told us their GP usually telephoned them back after morning surgery, which they felt was a good alternative to attending in person for minor issues.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & 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 last audit of complaints was carried out in January 2014 and was shared with NHS England and the CCG. In a twelve month period 11 complaints were received, of which seven were upheld. The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. For example, working patients taking anti blood clotting medication now had access to appointments in the evening The healthcare assistant's hours had been increased to provide an extended hours service and equipment purchased so that blood samples could be prepared and kept longer for collection the next day.

None of the eight patients we spoke with, or patients who gave written comments had ever made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager. One patient asked us why they would need to complain when the service they received was so good.

Are services well-led?

Good

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

Our findings

Vision and Strategy

There was clear leadership at the practice. Partner GPs provided robust business and clinical leadership in areas such as safeguarding and specialist care. Staff told us they felt they were well supported and enjoyed working at the practice. The changes and challenges staff faced at the practice related to embedding new IT and appointment systems. Staff said they received good levels of support through these changes. Staff knew how to raise concerns about whistleblowing and where they would report their concerns. Opportunities to give regular feedback and take part in pilots were evident. Care and welfare meetings, reflective practice, access to counselling services and de-briefing after serious incidents were embedded measures supporting staff. The majority of staff told us they felt very well supported.

Staff morale was very high at the practice. Staff said they felt valued and were encouraged to do the best for patients. Clinical and non clinical teams were managed in an open and transparent way at the practice.

Governance Arrangements

All 15 staff understood their role and responsibilities and demonstrated appropriate accountability in the way they supported and treated patients in their care. There were clear lines of accountability with regard to making specific decisions, especially decisions about the provision, safety and adequacy of the care provided and these were aligned to risk.

Senior GPs had lead roles, for example one GP was responsible for the protection of patients. Policies and procedures underpinning adult and children safeguarding at the practice were kept under review by this GP and referenced national guidance and current local safeguarding processes. Administrative staff held specific responsibilities for example with regard to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were escalated to the GP prescribing lead and were then discussed with the pharmacist who helped in raising awareness across the clinical team about potential risks and necessary actions to take.

Practice nurses told us they were supported through the local practice nurse forum and links with the modern matron and other specialist nurses at North Devon District hospital. The senior partner GP and practice manager carried out appraisals of the nurses. Training needs were identified and support given to staff to undertake additional training to increase their skill base. For example, one nurse was in the process of completing a diploma in management of patients with respiratory disease and was completing health checks of these patients with supervisory support until they felt confident to do this alone.

There were management systems in place to monitor the quality of the service provided. Regular reports were provided to the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG). This included performance information, clinical and strategic management. Referrals were monitored and there was a quarterly system in place for GPs to check each others referrals, for example, for appropriateness.

There were clear lines of reporting at the practice, which was clearly monitored through quality and safety processes. For example, one of these processes included senior GP partner oversight of emerging risks with vulnerable patients. A traffic light system was used to denote level of risks for these patients, which changed accordingly when reviewed. The team had a clear overview of the most vulnerable patients. Immediate, medium and longer term actions were in place to mitigate potential risks and promote patient safety, health and welfare.

Leadership, openness and transparency

The practice participated in the annual national Quality and Outcomes Framework (QOF). The practice worked to achieve targets called indicators in four main sections, called domains. These included clinical care which looked at long term conditions such as asthma and coronary heart disease to make sure the staff were caring for these patients in accordance with national guidelines. QOF results for the cycle 2012-13 were achieved by the practice, with some areas better than expected.

As well as directed audits the practice undertook some internal audits. These included analysis of complaints and feedback from patients and medicines management, leading to key lessons being shared across the team to improve the service. However, the audit cycle was not completed because these audits had not been repeated to ensure change was embedded.

Are services well-led?

Good

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

GPs met every day to discuss practice issues informally with nursing staff and there were regular formal meetings to promote good communication and team work. These included monthly meetings to review risks and issues arising for patients receiving palliative care, at risk of unplanned admission or with complex care needs, monthly clinical governance and business meetings between GP partners and the practice manager. There were also separate practice nurse meetings for nursing staff to catch up, share information and feedback.

Practice seeks and acts on feedback from users, public and staff

The importance of patient feedback was recognised and feedback mechanisms were advertised and easily accessible. The patient participation group (PPG) was used to provide patient voices to influence the service. The practice manager had taken steps to recruit patients from a range of ages and experiences to be part of the PPG.

Two representatives from the PPG met with us and explained that the group was autonomous and chose to invite the practice manager to chair meetings so that there was a two way process of communication. GPs at were said to be open and transparent with the group about the challenges facing the practice, clearly explaining when ideas could not be progressed. The representatives said that GPs always showed willingness to improve the service for patients and for example had made significant changes to the way carers were supported.

The practice held minutes of PPG meetings, which were published on the website along with an action plan showing how matters were being addressed and up to date progress with these.

Management lead through learning & improvement

We saw evidence that the practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. For example, an individual GP's contraceptive prescribing had been reviewed. This showed the GP was responsive to patient needs in their prescribing practice and potential risks had been explored with the patient. Another example seen was the revalidation of nurses in cervical screening every three years. Nurses held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients were reviewed by the lead nurse. Mentoring and support was provided for nurses to improve their skills and accuracy with such testing.

A random selection of staff files showed they had received an annual appraisal where training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff files contained evidence of professional training and reflection on specific issues. Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by their line manager who had appropriate skills, qualifications and experience to undertake this role.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients were not protected against the risks associated with medicines because the practice did not have appropriate arrangements in place for the safe keeping of stamped prescription forms and high risk medicines, which had been dispensed and were waiting for collection.**