Chilcote 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.

Contents

Summary of findings

Overall summary

Chilcote Surgery, is located close to Babbacombe in Torquay and provides services to 10,776 patients. A branch practice, Chatto Surgery is located about 10 minutes walk away. The practice has ground level access and is located on a main bus route making services accessible to people of all abilities. Both surgeries are registered with the Care Quality Commission with the registered manager having responsibility for both sites. Patients can see their preferred GP at either site.

We found the practice had taken steps to ensure their practice was safe for the patients it provided services to as well as to the staff employed there. There were systems in place to ensure effective patient care and we heard positive patient satisfaction with the services provided. Patients were cared for and treated with dignity and respect in an environment which was accessible and ensured their privacy. The practice was responsive in the way it provided services and responded positively to patient feedback. Appointments were available at times which suited the majority of patients, the practice used a very effective appointment system which placed the patient first. In the event of patients requiring to be seen urgently there was provision to accommodate their needs. Information was available for patients who required out of hours care on the providers website, in the practice and on their telephone system. The practice was well led by the registered manager, their partner GPs and nursing team. They were supported by a proactive practice manager and engaged staff team.

We talked with all staff employed in the practice who worked on the day of our inspection, this included four GPs and a locum GP, a practice nurse, a phlebotomist / health care assistant, the practice manager and six administrative staff. Two nurses from Torbay Hospital were also visiting the practice to carry out a national NHS screening programme. We spoke with 19 patients and received comment cards from a further 22 patients, this included speaking with three representatives of the patient consultation group of which there were about 600 members. The views expressed by these people about the practice were very positive with a collective view that patients were at the centre of the practice's service delivery.

Our GP specialist advisor spoke with the GPs about the following patient groups, older people, people with long-term conditions, mothers, babies, children and young people, the working-age population and those recently retired, people in vulnerable circumstances who may have poor access to primary care and people experiencing a mental health problem.

They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They provided us with examples of how they supported patients, these included, falls clinics for older people, prescribed fitness courses for people with long term conditions, weekly mother and baby clinics, extended working hours to support the working age population, clinics in a local homeless service four times a week, three clinics by GPs and one by a nurse for people in vulnerable circumstances, and working closely with the local crisis team to improve access to services for people experiencing a mental health problem.

The provider cited their flexible appointment system, working with the homeless organisation and their patient consultation group as being strong examples of their approach. Other examples included vaccination services, diabetes services, extended opening hours, and access to a GP of choice and gender through GPs providing services at two practice locations.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Patients were protected from the risks of abuse and avoidable harm as the practice took positive action to recognise risks and employed measures that ensured patient and staff safety. We saw that the practice learnt from incidents and complaints and improved day to day procedures to improve the services provided. Staff had received training in safeguarding vulnerable people and were aware of the types and signs of abuse. Where abuse was suspected the practice took appropriate actions and worked in partnership with relevant agencies. Medicines were managed safely and prescribing medicines was monitored in line with current guidance. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained. Recruitment was carried out effectively and staff received support once employed to ensure they provided safe services to patients, this included how to manage emergency situations which might arise in the practice. There were appropriate arrangements in place to manage emergency situations in the practice and emergency equipment was available to a team of trained staff.

Are services effective?

Care, treatment and support provided by the practice was effective. Patients stated high levels of satisfaction about the treatment they received and the outcomes they experienced. Patients needs were assessed and treatment was provided in line with expected standards and guidance. Best practice guidance was taken in to account and the practice ensured all staff had access to information about improving outcomes for patients. Outcomes for patients were routinely monitored and reviewed. Patients told us appropriate health care management plans were put in place to support their health and wellbeing. Staff told us they were very well supported by the provider and had access to information and training which helped them develop as individuals and as part of the practice team. There were effective working relationships with other providers and innovative ways of making services available to vulnerable groups of people. Health promotion and prevention was provided in a targeted and effective way by a practice which engaged effectively with patients.

Are services caring?

Patients told us about the quality of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We heard detailed accounts about

Summary of findings

how the nurses and GPs supported patients when their partners were unwell and about effective pain management. Patients told us their privacy was respected during treatment and when waiting for appointments. All GPs, nursing and midwifery staff were aware of the Gillick competency guidelines (a term used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge) when deciding whether a child was mature enough to make decisions for themselves. We saw how patients were involved in their care and treatment throughout their visit to the practice. Patients told us how their GP consulted with them about the choices of treatment available to them and how they were asked for their consent about treatment. Services were seen to be provided by caring and involved staff.

Are services responsive to people's needs?

The practice is responsive to patients needs. The practice understood the different needs of the population it served and acted on these to design services. The practice had established a patient consultation group (PCG) to help understand patient needs. The practice had worked with the group when carrying out patient surveys and had jointly identified areas of practice improvement. Information available in the practice promoted good health and wellbeing. Patients spoke positively about how continuity of care by doctors and other team members was provided, for example, appointments with a named doctor where possible. The majority of patients told us the appointments system was easy to use and provided choice for patients to access the right care at the right time. The practice had a clear complaints procedure which provided clear statements of how a response would be handled, who was responsible for managing the complaint and the time frame they could expect a response within.

Are services well-led?

The practice was well led by an engaged team of partners, an effective practice manager and a conscientious staff team. The leadership, management and governance of the practice assured the delivery of high quality patient centred care, supported learning and innovation within and outside of the practice and promoted an open and fair culture. The practice worked hard to provide services to the standards stated in their patient charter. Governance arrangements covered all aspects of the practice and minimised risks to patients. Patients spoke positively about their experiences within the practice and told us they felt the practice was well led, friendly and effective.

Summary of findings

What people who use the service say

A patient survey was carried out in November 2013 by the practice in conjunction with the patient consultation group. The survey showed high levels of patient satisfaction with the services provided. For example 98% of the 195 patients who responded were satisfied they were treated with courtesy and respect, a similar percentage of patients were satisfied that telephone response times were reasonable. We saw the results of the survey had been made available to all patients on the providers website alongside the actions agreed as a consequence of the patient feedback.

During our inspection all of the 19 patients we spoke with told us the practice and the support they received was good and they had a high level of satisfaction with all services, whether provided by the GPs, the nursing team or from the reception and administrative staff. Patients told our expert by experience they were mostly able to see the GP of their choice at a time which suited them and the treatment they received was provided in a safe and effective way. They also told us they found the environment was always clean and tidy and clinical staff, particularly nurses wore protective equipment such as gloves and plastic aprons during personal examinations.

Three of the patients we spoke with were representatives from the practice patient consultation group. This was a virtual group of around 600 patients who communicated via email and provided feedback to the practice. Some consultation group members were also part of Chilcote Care support group, there were plans for the group to meet directly with the practice once or twice each year. The group members were complimentary about the practice and about how the practice listened and responded to suggestions for practice improvement. They all told us they felt the practice provided safe and effective care and treatment in a clean and well managed environment.

We received comment cards from 20 patients. All the cards we received provided positive comments about the practice. Patients who made positive comments talked about exceptional doctors who listened and put patients first. They also highlighted how access to consultants and specialists was done promptly and how staff worked hard to keep patients informed.

Where comments were made about less satisfactory aspects of the practice, for example the telephone appointment system, we discussed these with the registered manager. We heard how the practice explained to patients the reasons why a change to a new system was required before the system was implemented. They recognised that some patients found the system unsatisfactory and showed us evidence that for most patients it had been beneficial. This was confirmed by the patients we spoke with, however the practice recognised reassurances were required for the few patients who felt adversely affected. We saw patients were invited to speak with the practice about the system in the practice's last newsletter.

Areas for improvement

Outstanding practice

The practice had about 114 homeless hostel patients. In recognition of this and the need to improve access to clinical services the practice had established a clinic in the main local hostel which supported homeless people. The GPs provided three clinics a week within the hostel whilst also making appointments available in the main practice for those who chose to visit there.

The practice had thought about information provision within the waiting area. For example, in the children's waiting area there were posters and leaflets relating to child development, child health and information for women during pregnancy. Another example was the provision of information about sexual health for 13 to 25

year old patients. To reduce embarrassment of having to ask for information or visit the main reception area, information was provided in the practice entrance along with testing kits for sexually transmitted diseases.

The practice had an engaged and active patient consultation group (PCG) of above average size. There were about 600 members of the PCG at the time of our inspection. We heard from members how they were involved in helping support the practice during their influenza vaccination period. The PCG members would be in the practice to meet and direct patients to the nurses providing vaccinations. This helped reduce the impact on the daily running of the practice and the need to involve the reception team.

The practice engaged with visiting consultants to help broaden their knowledge base as well as to inform their medical student programme. An example of where the practice had used best practice guidance followed updated guidance on reducing unplanned admissions into hospital. The practice identified 200 of their most vulnerable patients and held 'virtual ward' multi-disciplinary meetings to plan and deliver optimum care for each patient. This approach had helped to reduce the number of unplanned hospital admissions for vulnerable patients.

The practice provided a leg ulcer service which was delivered by the practice's nurses and health care assistants. Where need had been identified for patients living in a residential home, the practice had been instrumental in arranging for the tissue viability nurse to train staff at the home in order to provide the care required.

The practice provided a carer's support worker (CSW) who was based at Chatto Road surgery 2 days each week. Carers were seen at the practice or at home and were offered a health and wellbeing check as part of the CSW contact. Staff and GPs refer older patients to the CSW but patients could also contact the service directly. The CSW liaised with the hospital CSW when patients were discharged in order to ensure necessary support was in place on leaving hospital. In support of carers there were monthly meetings held with carers from another local practice called "Time Out". These meetings help extend the support offered to carers and the older people they supported.

The practice invited all newly diagnosed diabetic patients to attend a locally arranged group course in managing their diabetes. The GPs were also involved in the management of diabetes to ensure action was taken in response to any areas of concern. One of the nurses had her knowledge and awareness of diabetes developed and promoted insulin initiation, a service which had been provided by the practice for some years without the need for referral to the hospital. An annual audit of diabetic patients was performed with a multidisciplinary team meeting including the consultant diabetologist, to discuss action required for patients. Diabetic eye screening was also provided in the practice.

The practice ensured a tympanogram (an examination used to test the condition of the middle ear and mobility of the eardrum) was available in the practice to check for hearing problems such as glue ear (a condition where the middle ear fills with glue-like fluid instead of air) and identify indicators of deafness in babies and young children.

The practice ensured children and pregnant women who were eligible for flu immunisation were invited to attend the practice for vaccination. Patients aged 18 and over had the choice of Saturday mornings and late afternoon appointments as well as when they attend practice for other appointments. Separate clinics were provided for those under 18 to allow more time to see the patient.

The practice ensured two nurses and three GPs had undertaken additional sexual health training to increase their knowledge and skills to enable them to offer an enhanced sexual health service to young people.

The practice provided an additional specialist nurse service which was unique to the Torbay area. The service comprised of two nurses with administrative support, and aimed to complement and support the services already provided by the practice and community nurses. It provided a system of care for those patients in vulnerable circumstances who may have difficulty accessing services at the practice, and whose needs may be more appropriately met within their home environment.

The practice had a targeted alcohol worker, who covered all Torbay practices, who attended the virtual ward meeting each month and provided a service to patients with alcohol related problems. The practice had the

Summary of findings

highest number of admissions for alcohol related problems in the clinical commissioning group (CCG), the targeted alcohol worker was helping reduce the admission rate.

The practice liaised with a responsive improving access to psychological therapies (IAPT) service which was used regularly and was appreciated by the patients who could self-refer if they so wish. The practice also maintained close links with the third (voluntary) sector such as a local charity which provided support to patients and to access opportunities to make changes, to use and develop skills, pursue aspirations and recover a good quality of life. The practice had also welcomed three trainee counsellors to work with patients and help the counsellors in their development.

The registered manager, who is also the main partner, completed nine months psychiatry training at Exeter and Torbay to inform services to patients. At present they were working on a proposal to have mental health link workers attached to all practices. The registered manager was also a member of the Torbay Adults Safeguarding Board 2012 to 2013 which had resulted in a more informed staff team and safer care and support for patients with a mental health problem.

Chilcote Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our team was led by our Care Quality Commission (CQC) Lead Inspector. In addition, the team included a GP specialist advisor, a practice manager, a second CQC inspector and an expert by experience. Experts by experience are a part of the inspection team and are granted the same authority to enter registered providers premises as the CQC inspectors

Background to Chilcote Surgery

Chilcote Surgery, Dewerstone Practice, Hampton Avenue, Torquay TQ1 3LA is located close to Babbacombe in Torquay and provides services to about 10,700 patients. A branch practice, Chatto Surgery, 104 Chatto Road, Torquay. TQ1 4HY is located about 10 minutes walk away. The GPs serve both practices and patients, of which there are 10776 registered, can choose which practice to attend. The practice has level access and is located on a main bus route making services accessible to people of all abilities. The Practice has eight GP partners and patients can see their preferred GP at either site.

The practice had high Quality and Outcome Framework (QOF) scores. The QOF is the annual reward and incentive programme detailing GP practice achievement results. It is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004. The QOF awards practice achievement points for, managing some of the most common chronic diseases e.g. asthma, diabetes, how well the practice is organised, how patients view their experience at the practice, and the amount of extra services offered such as child health and maternity services. The practice was amongst the highest performance group within the local clinical commissioning group (CCG) for the following services, patient satisfaction, quality of service and access to services.

The practice has a higher number of patients aged under 18 compared to the CCG average, this figure is less than the national average. There are a higher proportion of patients aged 65 and over when compared to the England average. A higher score than the England and CCG average for Income deprivation affecting older people. The population which the practice serves has a higher deprivation score than the England average and a higher score than the England average for income deprivation affecting children. The ethnicity of the practice is predominantly White British with about 2.5% of patients stating they are from Black or Minority ethnic groups. Approximately 424 patients or 4% of the population group have either a learning disability, live in a residential or nursing home or live in a homeless hostel. The practice has arrangements in place to support all these patients.

The practice works in partnership with the Peninsula Medical School, supporting medical students as part of their experience in general practice. They run a computerised appointments system, and a sign translate service is available for deaf patients. Patients may choose to use a confidential translation service if English is not their first language. The services provided by the practice include: antenatal, asthma monitoring, cardiovascular disease screening, diabetes monitoring, family planning, child health clinics, child development checks, specialist nurse service and health visiting. The practice also offered vaccinations and provided child, seasonal flu and travel immunisations and advice. The practice also provides

minor surgery, cervical smear tests, blood pressure monitoring, smoking cessation, dietary advice, weight loss clinic, mental health counselling, physiotherapy and carers support.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, the Clinical Commissioning Group and the Local Medical Committee (LMC). We asked the provider to send us some information about their practice before the inspection took place to enable us to prioritise our areas for inspection. We reviewed the provider's website and looked at information provided by the NHS Choices and LMC websites about the practice.

During our visit, we spoke with a range of staff including four GPs, the locum GP, the practice nurse, the practice manager, reception staff, the administrative team and spoke with patients who used the practice. We observed how people were being cared for and talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice.

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

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

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

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

Are services safe?

Our findings

Patients were protected from the risks of abuse and avoidable harm as the practice took positive action to recognise risks and employed measures that ensured patient and staff safety. We saw that the practice learnt from incidents and complaints and improved day to day procedures to improve the services provided. Staff had received training in safeguarding vulnerable people and were aware of the types and signs of abuse. Where abuse was suspected the practice took appropriate actions and worked in partnership with relevant agencies. Medicines were managed safely and prescribing medicines was monitored in line with current guidance. The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained. Recruitment was carried out effectively and staff received support once employed to ensure they provided safe services to patients, this included how to manage emergency situations which might arise in the practice. There were appropriate arrangements in place to manage emergency situations in the practice and emergency equipment was available to a team of trained staff.

Safe patient care

Patients were able to access the GP of their choice during the opening hours of the practice. Appointment times varied based on patient needs, appointments varied from a five minute telephone discussion appointment to twenty minute consultation appointments. Longer appointments were available if required, for example if a patient needed to have an examination with the practice nurse. Emergency appointments were available each working day and the practice had extended working hours from 7:30am up to 7pm.

The GPs and nurses we spoke with told us about routine condition and medicines reviews. The patients we spoke with confirmed these reviews. Patient care was provided by clinicians who routinely updated their knowledge and skills from a variety of sources. For example, attending learning events provided by the clinical commissioning group, completing online learning courses and reading journal articles. Learning also came from clinical audits. For example, audits of patient records by a medical student identified patients who had not received cervical smear tests for more than 12 months. The practice had taken action to ensure patients who had missed tests were contacted and invited to attend the practice for a routine test.

The practice has an electronic patient record system as well as an older paper based system. Alerts were placed on the electronic patient record to indicate significant medical concerns about patients as well as allergies or the need for additional support. These alerts appeared immediately when the patient record was opened and alert the clinician to anything significant relating to the patient and the patients care. Routine recall appointment alerts were entered onto the system to ensure patients were reminded to have their medical conditions reviewed. Patients were sent reminders such as a text message or letter to attend appointments as part of a process to reduce the number of patients not attending appointments.

Learning from incidents

There had been very few incidents relating to the practice. Where an incident had occurred, we saw there were effective measures in place to learn from the incident and avoid repeated problems. For example, where a patient's wheelchair had become stuck in a doorway, we saw the incident had been investigated to find out how the problem occurred. We heard from the practice manager how they reviewed and amended where the patient was seen, to reduce the risk of the incident recurring. We saw that this information was passed on to the staff team at a subsequent meeting. There had been no further incidents relating to this type of problem. Other incidents were investigated in the same way and communicated to relevant staff at meetings as soon after the event as possible to avoid repeat incidents.

The GPs we spoke with told us about learning from every day occurrences as well as complaints. They told our accompanying GP that complaints were managed by the practice manager and learning was then shared with staff once the complaint was resolved to the patient's satisfaction. This was confirmed in the staff meeting minutes we saw.

Safeguarding

One of the GP partners had a practice lead responsibility for ensuring safeguarding of vulnerable adults and children and there was a practice expectation that all GPs were trained and aware of the signs and types of abuse and who to contact where there were concerns. We were told that all

Are services safe?

GPs completed annual safeguarding training. There were appropriate policies available in the practice and information about local safeguarding teams was on staff and patient noticeboards. We were told by the registered manager there had been very few concerns recently. There were a number of children known to the practice on the child protection register, where concerns had been identified we saw evidence that the concerns had been reported to the relevant bodies.

All the staff we spoke with demonstrated a good understanding of the types of abuse which might occur as well as the signs and symptoms of abuse. We saw telephone numbers of relevant agencies relating to safeguarding concerns were available in the practice. The staff we spoke with told us they had completed safeguarding training and this was confirmed when we looked at the training records for those staff.

The patients we spoke with told us they felt safe in the practice and their care and support was delivered by respectful and professional staff. The practice had a chaperoning policy available to all patients which ensured all vulnerable patients had the opportunity to see a GP or nurse accompanied by a skilled and knowledgeable chaperone.

Monitoring safety and responding to risk

We saw that staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. For example, five GPs were available on Monday and Friday, four GPs available on a Tuesday whilst there were three GPs available on the other weekdays. Five nurses were similarly flexibly available as was the phlebotomist (a person trained to take blood samples). These levels of staff were seen during our inspection. This showed the right staffing levels and skill-mix was sustained at all hours the practice was available to help ensure safe, effective and compassionate care and levels of staff well-being.

We saw a range of information was available within the practice. This provided details of organisations that patients or staff could contact if physical health emergencies or mental health crises occurred either during or outside of practice opening times. The reception staff showed us contact telephone numbers of relevant organisations they could contact and there was a detailed emergency incident procedure available in the practice. Staff told us how they recognised and responded to changing risks within the practice, for patients and for staff. Staff told us about recent training they had received in what to do in an urgent or emergency situation and about the practices procedure in such circumstances. An emergency call system was available throughout the practice for staff to summon assistance if required.

We saw there was sufficient and up-to-date emergency equipment available for use by all trained and competent staff working in the practice. Routine checks of this equipment were undertaken by designated staff members. Emergency medicines were also available in a central area of the practice and were routinely audited to ensure all items were in date and fit for use. We looked at all this equipment and saw it appeared to be in working order and in date.

Medicines management

We looked at the arrangements the practice had for managing medicines. We found a clear prescribing procedure was available within the practice. All staff told us they understood the procedure. The procedure covered prescribing medicines, repeat prescriptions, reviewing prescribed medicines and prescription authorisation processes. These helped ensure the safe prescribing of medicines to patients.

Medicines which required storage in a refrigerator were stored appropriately and within the safe temperature ranges described in the medicines packaging. Fridge temperatures were monitored and recorded daily. Vaccines were similarly safely stored. Medicines were held securely in a specifically designed cabinet with keys accessible to a limited number of the practice staff. The practice pharmacist routinely audited these medicines with specific members of the administrative team in the practice to account for medicines and to monitor expiry dates.

Two separate staff members told us about routine monthly audits of expiry dates for emergency medicines. All the medicines seen were in date and fit for use, however temperature monitoring in the treatment room where medicines were stored was not routinely undertaken and could lead to medicines becoming less effective if not stored correctly. Where medicines were reaching their expiry dates there was a system in place to ensure these were prioritised for use. This ensured patient safety and the effectiveness of their treatment.

Are services safe?

Prescription pads were held securely. Serial numbers of the pads were recorded on receipt to ensure accountability and to aid auditing. When given to GPs, the serial number of the pad was recorded and the pad became the responsibility of the GP.

Cleanliness and infection control

Patients were cared for in a clean, hygienic environment. We carried out a visual check of all areas of the practice and observed that all areas appeared clean, tidy and free of items which may cause infection control risks. Clinical areas of the surgeries had designated clinical spaces with surfaces which could be wiped clean or washed. Appropriate personal protective equipment such as examination gloves, plastic protective aprons and surface cover sheets were available in these areas and were stored appropriately. There were separate hand and instrument washing facilities, alcohol gels were also available throughout the practice.

The practice nurse had a lead responsibility for ensuring effective infection control. Staff had received training to ensure effective hygiene practices were maintained. Appropriate signage was available throughout the practice that reminded staff and patients about good hygiene practices. Routine hygiene audits were undertaken in accordance with the provider's infection control policy. There was a schedule of cleaning requirements. The practice manager routinely checked that all areas had been cleaned to the standards required.

Medical equipment used in patient examinations was mainly single use items which were then disposed of appropriately. Where equipment could be used again we saw equipment was stored appropriately until it was collected for cleaning by a specialist cleaning contractor. Cleaned equipment was hygienically packaged and date stamped to indicate when it should be used by. All equipment was in date. Waste bins were foot operated and lined with the correct colour coded bin liners. We saw waste was stored in locked bins until it was regularly collected by a recognised waste disposal contractor. Clinical sharp objects such as needles were disposed of in recognised sealed containers and disposed of in line with current guidance.

Patients were protected from the risk of infection because appropriate guidance had been followed. The practice employed a cleaning service for the five days of the week the practice was open. All cleaning materials and chemicals were securely stored and Control of Substances Hazardous to Health (CoSHH) information was available to ensure their safe use. Surgeries were deep cleaned as required and at least annually.

Staffing and recruitment

The provider had relevant staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. Most staff had been employed by the practice for long periods with few staff having been employed recently. We saw from the paper and computer staff records we looked at that staff had been recruited and employed in line with the provider's policy. For example, following the advertising of a post the application forms had been checked and a short list for interviews had been made. We saw evidence that interview performance had been measured and a decision to appoint had been reached. Verbal and written job offers had been made.

Before staff were appointed there was evidence that relevant checks had been made in relation to identity, registration and continuous professional development. Disclosure and Barring Service (DBS) (used to check criminal records) checks had also been made. However for two recently appointed members of non-clinical staff, who may have access to vulnerable patients, we saw a DBS check had not been carried out. We discussed this with the practice manager and registered manager and heard that when requesting this type of check they had been advised one was not required and that a risk assessment had been completed to ensure patient safety. Following our discussions the practice manager told us they would reapply for the DBS check.

We saw the current detailed induction plan for a newly appointed member of staff. The plan showed they had completed many areas based on their role such as telephone answering, patient care and safety, health and safety and fire procedure familiarisation. We saw they received training and support around the use of the patient records system and were closely supervised ahead of taking on their new role. All the staff we spoke with told us they felt supported by the GPs and nursing team as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role. The patients we spoke with told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Are services safe?

Dealing with Emergencies

The provider had arrangements in place to manage emergencies. All staff recently had completed basic emergency first aid training and were able to tell us the locations of all emergency medical equipment and how it should be used. We checked the medical equipment and found it appeared to be in good working order, had recently been checked and was appropriately accessible. Equipment was available in a range of sizes for adult and children.

Emergency medicines were available in a secure area of the practice. All medicines were in date and fit for use and were routinely checked by the practice nurse. They held a list of the medicines expiry dates and had a procedure for replacing medicines at that time.

The providers computer based records system had an alerting system in place which indicated which patients might be at risk of medical emergencies. This enabled practitioners to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable, for example through poor mobility or where epilepsy was diagnosed. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

Emergency appointments were available each day both within the practice and for home visits. Out of hours emergency information was provided in the practice, on the provider's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required. This demonstrated the provider had arrangements in place for dealing with emergencies.

Equipment

Equipment and facilities for the practice were sufficient to meet the needs of patients. An on going maintenance programme was in place. The practice had been proactive in making reasonable adjustments to ensure accessibility. They had recognised the problems an upstairs treatment room might cause and had moved all surgeries to the ground floor. Access into the practice had been made easier by the placement of a shallow ramp into the practice entrance. Patient toilets with facilities for disabled patients were accessible in two locations on the ground floor. The practice ensured the environment and facilities were appropriate and required levels of equipment were available in all surgeries.

We looked at the equipment available within the practice, together with the arrangements in place that ensured the equipment was serviced and safe to use. We saw that equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED) centrally located, all staff were trained in its use.

All portable electrical equipment was routinely portable appliance tested (PAT) and displayed stickers indicating testing, in some instances old stickers had not been removed making date identification difficult. A schedule of re-testing was in place however it was not clear whether the practice or an NHS contractor was responsible for the testing. We heard and saw the equipment was not moved, this helped minimise the risks to patients and staff. Single use examination equipment was stored hygienically and was disposed of after use. Other equipment was wiped down, cleaned or sterilised after use by a recognised contractor. If equipment became faulty or required replacement, these were referred to the practice manager who arranged for their replacement. Equipment such as the computer based record system were password protected and backed up to prevent data loss.

Are services effective?

(for example, treatment is effective)

Our findings

Care, treatment and support provided by the practice was effective. Patients stated high levels of satisfaction about the treatment they received and the outcomes they experienced. Patients needs were assessed and treatment was provided in line with expected standards and guidance. Best practice guidance was taken in to account and the practice ensured all staff had access to information about improving outcomes for patients. Outcomes for patients were routinely monitored and reviewed. Patients told us appropriate health care management plans were put in place to support their health and wellbeing. Staff told us they were very well supported by the provider and had access to information and training which helped them develop as individuals and as part of the practice team. There were effective working relationships with other providers and innovative ways of making services available to vulnerable groups of people. Health promotion and prevention was provided in a targeted and effective way by a practice which engaged effectively with patients.

Promoting best practice

Patients care and treatment needs were assessed and care and treatment were delivered in line with current legislation, standards and guidance. The practice subscribed to a range of medical journals, publications and online resources which provided and indicated recognised evidence-based practice. Each GP ensured they developed their knowledge and skills through a continuous professional development pathway. The GPs had their professional development checked annually during appraisal and revalidation, this took place every five years. The practice nurses completed a similar pathway and were supervised by the GPs, the nurses told us they used these opportunities as well as regular GP contact to hear more about best practice guidance.

The provider told our GP specialist advisor about how they also attended regular meetings at their clinical commissioning group (CCG) where they held a lead role for finance and clinical governance. The practice engaged with visiting consultants to help broaden their knowledge base as well as to inform their registrar GP programme. An example of where the practice had used best practice guidance followed updated guidance on reducing unplanned admissions into hospital. The practice identified 200 of their most vulnerable patients and held 'virtual ward' multi-disciplinary meetings to plan and deliver optimum care for each patient. This approach had helped to reduce the number of unplanned hospital admissions for vulnerable patients.

We saw the provider was in routine receipt of the latest medicines and healthcare products regulatory agency (MHRA) alerts which enabled the practice to ensure effective treatment of patients. The practice also subscribed to the British National Formulary (BNF) which provided guidance and best practice about the safe use of medicines. Access to these resources supported the effective treatment of patients.

The patients we spoke with told us their care and treatment was personalised and supported their recovery and helped them to maximise their health and well-being and quality of life. One patient told us about the treatment they received following the identification of cancer and how the practice liaised with consultants and specialists to ensure they received the most effective treatment. They told us the treatment they were receiving had controlled the cancer and had enabled them to retain a good quality of life. They said they did not believe they would be alive without the treatment their GP had provided.

Management, monitoring and improving outcomes for people

The patients we spoke with who had long term conditions told us their conditions were well managed, routinely monitored and had found their health conditions had stabilised leading to improved heath. For example, where patients required treatment to prevent the formation of blood clots in their blood vessels, an effective management program was in place. Routine repeat blood test appointments were arranged with the phlebotomist or nurse. The results of the blood tests were evaluated by the clinicians and the appropriate adjustment was communicated to the patient the same day. The nurse kept a record of the test results in the patients record book to monitor progress and to identify variations in the patients condition. These routine tests enabled patients to maintain positive health outcomes. We saw similar monitoring and management programs for people with diabetes, iron deficiency, heart conditions, prostate cancer, arthritis and near-patient testing (medical testing at or near the site of patient care) for patients on certain medicine types. This type of monitoring supported effective outcomes for patients using the practice.

Are services effective?

(for example, treatment is effective)

Staffing

The provider had effective staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. The majority staff had been employed by the practice for over a year with few staff having been employed recently. The staff we spoke with told us they all received an annual appraisal and attended regular staff meetings to enable information sharing. The minutes of staff meetings we asked for confirmed this. Nursing staff received clinical supervision from the GP partners with the GPs meeting informally to discuss clinical issues and diagnosis. All staff told us they had access to training related to their roles, all had recently completed basic emergency first aid training. Staff told us they were alerted to concerns about faulty equipment from medicines and healthcare products regulatory agency (MHRA) alerts by the practice manager.

The practice actively encouraged staff to develop their skills and knowledge and supported staff to change roles. For example we heard about training arranged by the practice which enabled a receptionist to become a health care assistant. Additionally one of the administrative team was given time and access to train to become a nurse within the practice. Similarly a nurse was supported to become a nurse practitioner. Staff told us they valued the development opportunities that had been provided to them and felt the practice was a good employer. These meant patients were treated effectively by informed staff.

All the staff we spoke with told us they felt supported by the GPs and nursing team as well as by the practice manager and each other. They told us they felt skilled and received opportunities to fulfil and develop their role through a range of learning opportunities such as, online learning and in-house training. The patients we spoke with told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with other services

We saw and heard how the provider had effective working arrangements with a range of other services such as, the community nursing team, the local authority, local nursing and residential services, the hospital consultants and a range of local and voluntary groups. A particularly good example of how the provider worked with other services was in the way they improved access to clinical services for vulnerable patients. The practice had recognised that homeless patients felt uncomfortable attending appointments and other patients felt intimidated by their presence in the practice. To respond to this issue the practice established a clinic in the main local hostel which supported homeless people. The GPs provided three clinics a week within the hostel whilst also making appointments available in the main practice for those who chose to visit there.

Other examples of working with other services were liaison with the diabetic clinic at Torbay hospital and working with residential and nursing homes to establish effective end of life care in accordance with the Mental Capacity Act 2005. Additionally the involvement of the main GP in the clinical commissioning group and one of the other GPs working with the Torbay federation which will enable 37 local practices to bid for contracts to deliver enhanced services in the locality were examples of partnership working.

The patients we spoke with told us about timely referrals to specialists and consultants for further tests or treatment. They also told us how they were referred to the support groups for support at times they were in need as well as community nursing provided services. We saw GPs carry out home visits for independent patients and for those requiring residential or nursing care. The patients told us how once they had received test results or treatment their GP received information promptly with test results and suggestions for on-going treatment and support. These were followed up by appointments at the practice.

During our inspection we spoke with nurses who carry out screening for certain groups of male patients. They confirmed to us there were effective working relationships with the practice. They told us referrals were provided in a prompt manner and that when they contacted the GPs for further information or suggested further treatment, they were responded to positively and promptly.

Health, promotion and prevention

The practice demonstrated they had thought about information provision within the waiting areas. For example, in the children's waiting area where mothers would take their children, there were posters and leaflets relating to child development, child health and information for women during pregnancy. Another example of targeted information provision was information about sexual health for 13 to 25 year old patients. To reduce embarrassment of having to ask for information or visit the main reception

Are services effective?

(for example, treatment is effective)

area, information was provided discretely in the practice entrance along with testing kits for sexually transmitted infections. Similar information was available on the providers website.

The practice offered a range of health promotion and prevention information to all patients using the practice. The promotion and prevention was provided as part of normal GP and nursing appointments. It was supported by a range of well organised information within the practice and on the provider's website. Information was available about, health and lifestyle issues such as keeping healthy, living a healthy lifestyle, preventing illness, and preventing any existing illness from becoming worse. Leaflets included information on diet, obesity, smoking, exercise, alcohol, preventing heart disease, cervical screening, breast screening, sun and health. Information and advice was also available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support. Information on the practices website also included information about self-help. Information such as this helped patients to avoid unnecessary calls to the practice and enabled them to access ways of relieving signs or symptoms of illness.

Are services caring?

Our findings

Patients told us about the quality of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We heard detailed accounts about how the nurses and GPs supported patients when their partners were unwell and about effective pain management. Patients told us their privacy was respected during treatment and when waiting for appointments. All GPs, nursing and midwifery staff were aware of the Gillick competency guidelines (a term used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge) when deciding whether a child was mature enough to make decisions for themselves. We saw how patients were involved in their care and treatment throughout their visit to the practice. Patients told us how their GP consulted with them about the choices of treatment available to them and how they were asked for their consent about treatment. Services were seen to be provided by caring and involved staff.

Respect, dignity, compassion and empathy

The patients our expert by experience spoke with told them about the quality and value of the treatment they received. They told us about the respect, dignity, compassion and empathy they were shown by all members of the practice team. We heard detailed accounts about how clinical staff supported patients when their partners were unwell, about effective pain management for a person who was dying and the high degree of emotional support they received from their GP. Patients told us how they were referred to the Carers group provided by the practice and how this additional support helped patients come to terms with the loss they experienced.

Information received on comment cards completed by patients before and during our inspection made similarly positive comments about the way patients were treated and the professionalism of clinical and administrative staff.

We saw how the reception staff treated all patients with dignity and respect when they arrived for appointments. Patients were greeted in their preferred manner and conditions were not discussed in a way which could undermine their privacy. The reception area was screened from the waiting area which further aided patient privacy.

When patients were called for appointments, the GP or nurse came out to collect the patient and welcomed them by name. All patients were seen in private unless they chose to be accompanied by a partner, parent or chaperone. Surgery doors were closed and clinical examination areas were screened to ensure patient privacy and dignity. All surgeries were separated from the waiting area. We saw that staff did not enter the surgeries unannounced during our inspection, demonstrating patients privacy and dignity were respected.

All clinical staff were aware of the Gillick competency guidelines (a term used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge). Where this was the case, we were told patient records would be updated to reflect the current arrangements.

Where patients lacked the capacity to make decisions about their health, we heard how the clinician would liaise with the patients partners or carers and undertake best interest decisions under the Mental Capacity Act 2005, to ensure the patient received appropriate treatment. Where patients were forgetful and accompanied by a carer, we heard and saw how clinical staff spent time with the patient, explained what was happening and reassured them in a compassionate and dignified.

Involvement in decisions and consent

The patients we saw told us they were involved in their care and treatment throughout their visit to the practice. We saw how new patients were asked to complete new patient information forms, which included details of their previous health conditions and current medicines they took. We heard from staff and patients how a first appointment was usually a health assessment consultation and how they signed forms agreeing to their care and treatment. The practice electronic booking in system for appointments was available in seven languages and aided patients involvement in their treatment.

Patients told us how their GP consulted with them about the choices of treatment available to them and in how that treatment could be provided. For example, the patient could have minor treatment carried out in the practice by one of the GPs or if they preferred they could be referred to one of the local hospitals. One of the patients we spoke

Are services caring?

with told us how they were offered the choice of a consultant at two regional hospitals. They told us how they were given information about the consultants involved before they decided where to receive that treatment.

Other patients told us about consent forms they signed to agree to the treatment they required. Consent forms were available in the waiting area for permission to share information, agreement to receive text message appointment reminders and agreement to see visiting clinicians or nurses. The forms included the risks of the treatment, as well as having the treatment and the alternatives explained. These signed forms were kept on the patient records. This showed patients were consulted with and their choices taken into account. All patient records were stored securely.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice is responsive to patients needs. The practice understood the different needs of the population it served and acted on these to design services. The practice had established a patient consultation group (PCG) to help understand patient needs. The practice had worked with the group when carrying out patient surveys and had jointly identified areas of practice improvement. Information available in the practice promoted good health and wellbeing. Patients spoke positively about how continuity of care by doctors and other team members was provided, for example, appointments with a named doctor where possible. The majority of patients told us the appointments system was easy to use and provided choice for patients to access the right care at the right time. The practice had a clear complaints procedure which provided clear statements of how a response would be handled, who was responsible for managing the complaint and the time frame they could expect a response within.

Responding to and meeting people's needs

Through the information we received from the practice and our observations during our inspection we saw the practice understood the different needs of the population it serves and acted on these to design services. The practice had established a patient consultation group (PCG) of over 600 members to help understand patient needs and views. The group was made up of a representative sample of the patients receiving services but with a slight bias towards patients over 55 years old. The practice had worked with the group when carrying out patient surveys and had jointly identified areas of practice improvement. The practice had recently added the facility of a suggestion box and suggestion cards to gain patient feedback and had also used information from complaints to improve the practice.

For the majority of patients using the practice the successful implementation of a patient appointment system had provided significant benefits over the previous appointment system. Access to GPs for advice or appointments had improved alongside extended practice opening times. We saw patients visiting the practice to see their GP before 8am and appointment slots were available in the evening up to 7pm. Patients were now usually able to get to see the doctor of their choice at a time which suited the patient and usually on the day they called. This had enhanced the continuity of care provided by the GPs.

Information available in the practice promoted good health and wellbeing and the clinical teams worked with patients to promote self-care and patient independence. Telephone calls or text messages for follow up appointments were made to patients with long term conditions. These ensured they were following guidance provided by clinical staff or to remind them to attend their appointments.

Patients spoke positively about how continuity of care was provided by doctors and other team members, for example, appointments with a named doctor where possible. This was maintained as each GP spoke with the patient before appointments were made and on the basis of that conversation patients were offered available appointments to their preferred GP.

Access to the service

Information was available on the practices website for patients about how to get the most from their appointment with the GP. This information helped patients to access the practice more effectively and make the most of their appointment with their GP.

The majority of patients we spoke with told us the appointments system was easy to use and provided choice for them to access the right care at the right time. Patients who used the practice were easily able to contact the practice to make an appointment. Appointments could be made by telephone or by using the provider's online appointment booking system, although on the day of our inspection that was not working due to a change in IT systems. Where patients did not find the system easy to use they told us they were still able to pop into the practice to make appointments. We saw patients using this approach and saw they were provided with appointments at a time which suited them.

Opening hours had been amended and now met the needs of the majority of the practice population. Opening hours were clearly stated on the entrance to the practice, in the practices brochure and their personal and NHS Choices website. The appointments system was monitored to check how the appointments system worked and to highlight where non-attendance occurred, the new patient appointment system had reduced non-attendance at the

Are services responsive to people's needs?

(for example, to feedback?)

practice. One comment card we received stated the call back system was sometimes difficult for working patients as some employers did not like personal phone calls being received during working time.

There was a system in place to enable requests for same-day appointments to be met. We spoke with four patients who had phoned up that morning and were offered appointments to see their chosen GP, they expressed satisfaction with this response. The practice monitored its systems for appointments and waiting times and informed patients when delays of over fifteen minutes occurred.

Patients were able to be assessed by a GP in a timely way which meets their needs. This included, for example, urgent appointments if needed or telephone consultations and home visits for patients that would benefit from them. We saw there were a range of appointment slots available from short telephone conversation consultations to ten minute single and twenty minute double appointments. Longer appointments were also available where minor surgery was being provided.

The patients we spoke with told us services were planned in a way that promoted person-centred and coordinated care, including for patients with complex or multiple needs. Patients and GPs told us about referrals to consultants, treatments provided in hospitals and how their own GP followed these appointments with on-going treatment plans or routine monitoring depending on patient needs and the outcome of the treatment provided.

The practice was proactive in removing barriers that some people face in accessing or using the service. The practice had about 114 homeless hostel patients registered. In recognition of this and the need to improve access to clinical services the practice had established a clinic in the main local hostel which supported homeless people. The GPs provided three clinics a week within the hostel whilst also making appointments available in the main practice for those who chose to visit there.

Concerns and complaints

The majority of patients told us they knew how to raise concerns or make a complaint about the practice. The practice complaints procedure was promoted on the patient notice board, in the practices brochure and on their website. Where patients were unsure of the policy, they told us they felt that if they complained to the doctor or receptionist their complaint would be listened to and acted on.

The practice had a clear complaints procedure which provided clear statements of how a response would be handled, who was responsible for managing the complaint and the time frame they could expect a response. There had been 13 complaints to or about the practice in the previous twelve months. The main theme of the complaints appeared to be about poor communication between staff and patients. Where complaints had been made we saw they were responded to as described in the practice policy and in writing to the patient where appropriate. Where complaints were about staff, we saw the practice manager spoke with those involved and offered them support to improve their performance. Where they were about systems we saw efforts had been made to improve services. A recently implemented computer system upgrade was an example of improved services in response to patient comments. This ensured that performance was reviewed and services were improved for patients.

Patients who made informal complaints or comments told us the practice had handled their complaint effectively, and treated them with respect throughout the process. The practice explained in writing in an open and honest way what had happened as a result of the issues being raised. The patients we spoke with told us they had no current concerns about the practice which indicated a high level of patient satisfaction with the practice.

Are services well-led?

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

Our findings

The practice was well led by an engaged team of partners, an effective practice manager and a conscientious staff team. The leadership, management and governance of the practice assured the delivery of high quality patient centred care, supported learning and innovation within and outside of the practice and promoted an open and fair culture. The practice worked hard to provide services to the standards stated in their patient charter. Governance arrangements covered all aspects of the practice and minimised risks to patients. Patients spoke positively about their experiences within the practice and told us they felt the practice was well led, friendly and effective.

Leadership and culture

The practice had eight partners each of who had lead roles in areas such as palliative care, dermatology, clinical governance, mental health and safeguarding vulnerable patients. One of the partners also had a lead responsibility for GP training and the supervision of medical students. One GP had recently completed his training to allow him to train GP Registrars which the practice hoped to do very soon. The practice manager took lead responsibility for the day to day management of the practice and acted as a link between the GPs, staff and patients. The practice nurse had responsibility for infection control and ensured adherence to practice policy across the staff team. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other.

Staff were able to tell us about the values and philosophy of the practice and this encompassed key concepts such as compassion, dignity and respect, equality and quality which placed the patient at the centre of decision making. A patient charter had been developed by the clinical team and more latterly with input from key stakeholders that included patients and staff. Evidence seen during our inspection indicated the practice was achieving these objectives and the whole team worked towards achieving the values described. This evidence was corroborated by patients who told us they felt the practice was well led and there was a positive culture of patient care.

The practice actively encouraged staff to develop their skills and knowledge and supported staff to change roles. For example we heard about training arranged by the practice which enabled a receptionist to become a health care assistant. Additionally one of the administrative team was given time and access to resources to train to become a nurse within the practice and a nurse to become a nurse practitioner. Staff told us they valued the development opportunities that had been provided to them and felt the practice was a good employer.

Governance arrangements

Governance arrangements were effective and supported transparency and openness. We saw the provider had a range of governance policies and protocols which covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance.

There was a clear staff list detailing individual areas of governance responsibility. The practice staff we spoke with were clear about what decisions they were required to make, knew what they were responsible for and fulfilled their role. For example, where a nurse was responsible for checking emergency medicine expiry dates this check was carried out, where fridge temperatures required monitoring to ensure travel vaccinations remained useable these were recorded in a vaccinations log. The staff we spoke with told us the practice had a culture of routinely auditing activities, the records and logs we saw confirmed these statements.

Clear lines of responsibility for making specific decisions about the provision, safety and adequacy of the care provided at practice level were defined in the practice. The practice nurse we spoke with told us how they always referred patients back to the GPs where medical conditions changed and collaboratively they agreed the best course of action to involve and support the patient. An example of this approach was where a patients blood test showed a change which required medicines adjustment. The nurse would inform the GP and they would discuss the relevance of change before advising the patient of the change.

The practice ensured that any risks to the delivery of care and treatment were identified and mitigated before they became issues which adversely impacted on the quality of care. For example, the practice had a business continuity plan which considered a detailed range of circumstances which might impact on service delivery. These were mitigated by a range of actions that were aimed to ensure the continuity of the service and contained a detailed list of contact telephone numbers where further advice could be gained. The practice had two surgeries and so could move patient care to the other practice if the need should arise.

Are services well-led?

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

There were processes in place to ensure high quality care was being delivered. The GPs our accompanying GP spoke with told us they continually reviewed their patients and patient records were reviewed at each patient appointment. The nursing team were supervised and appraised by the GPs, patient care formed part of these reviews. Reception staff were observed by the reception co-ordinator to ensure patients were appropriately cared for on arrival to the practice. All staff had a responsibility to ensure patient safety was maintained and where concerns were observed in relation to vulnerable people, we saw these were reported to relevant organisations including the local authority.

The practice placed importance on quality data and information, this supported clear decision making within the practice. We heard from the practice manager how they regularly maintained their Quality and Outcomes Framework (QOF) (A voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients) information to ensure it was populated with the latest practice information. We saw the practice routinely gathered patient feedback from patients via suggestions and questionnaires and used this information to improve the practice. We heard from the practice manager how they used clinical commissioning group (CCG) audits to inform their own governance reporting and practice improvement action plans. The practice website was well maintained and informative and provided patients and potential patients with information about the practice and practice improvements. The practice sought to use information to improve the practice.

Systems to monitor and improve quality and improvement

The practice was proactive in gaining patient feedback. A patient survey was carried out on the 29 October 2013 by the practice in conjunction with the patient consultation group. The survey was collated in February 2014 and published in March 2014. It showed high levels of patient satisfaction with the services provided and contained a large number of positive comments about the practice. For example 86% of the 195 patients who responded were satisfied they could get an appointment more easily since the implementation of a new patient appointment system. A much higher percentage of patients (98%) stated they were treated with courtesy and respect. Where less favourable comments were made, for example a lack of awareness about recently implemented systems and data sharing, we saw the practice had completed an action plan to raise patients awareness. We saw the results of the survey had been made available to all patients on the providers website alongside the actions agreed as a consequence of the patient feedback.

Patient experience and involvement

Our expert by experience spoke with patients visiting the practice. Patients spoke highly of the practice and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. Other comments made to our expert by experience confirmed that patients were consulted about treatments available to them, were asked for consent before they were examined by clinical staff and felt the treatment they were provided with improved their conditions.

Two patients reported to us that medicines reviews indicated on their repeat prescription slip had not been carried out by the date indicated on the slip. They told us that when they raised this with their GP a review took place. Information from the practices patient survey indicated that about 2% of patients found making an appointment with the nursing team difficult. The practice action plan had actions to improve this last point.

The practice had established a patient reference group which was used to inform the services development. Patients from this group we spoke with told us they felt their involvement was valued. We heard from group members about how they supported the practice at busy times, for example during flu vaccination clinics where they helped organise and direct patients to the nurses providing the vaccinations. The group also provided a voluntary driver scheme to help patients get to appointments. The patients we spoke with told us about the excellent service they received from all clinical and non-clinical staff.

The practice sought and acted on feedback from users and the public. It carried out surveys using the patient consultation group, had suggestion slips available in the practice and had feedback mechanism's on its website. Comments were collated and actions were taken to improve the practice. For example a new patient appointment system and extended opening hours had been implemented following patient feedback. The way the waiting areas had been set out was also in response to comments made by patients.

Are services well-led?

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

Staff engagement and involvement

We spoke with a range of staff including four GPs, the locum GP, the practice nurses, the practice manager, reception staff and the administrative team. All the staff we spoke with told us they felt involved in the day to day running of the practice as well as the longer term functions of the practice. We saw records which showed how staff were involved in staff meetings and saw how they discussed a range of practice issues. The minutes from these meetings showed how staff were involved in the planning around staff changes, registering new patients and planning for their travel clinics vaccination programme.

We saw how many of the staff team had multiple roles in the practice, for example acting as relief receptionists and supporting the administration functions. Staff in these roles told us this enabled them to pass on knowledge and observations to the clinical teams. The practice actively encouraged staff to develop their skills and knowledge and supported staff to change roles. For example we heard about training arranged by the practice which enabled a receptionist to become a health care assistant. Additionally one of the administrative team was given time and access to train to become a nurse within the practice and a nurse to become a nurse practitioner. Staff told us they valued the development opportunities that had been provided to them and felt the practice was a good employer.

Learning and improvement

During our discussions with the staff across the practice we found there was a clear understanding of the current and future leadership needs of the practice. This included ongoing leadership development and succession planning. For example, we heard about staff development which allowed staff to gain qualifications to take on other roles within the practice to facilitate the range of services offered. We heard from staff at all levels about how the partners encouraged cooperative, appreciative, supportive relationships among staff through daily contact with them, regular meetings and frequent information updates. Staff told us they felt supported, valued and motivated and told us they were treated fairly and compassionately at all times.

All practice staff met regularly. Mechanisms were in place to support staff and promote their positive wellbeing. Employment practices, including effective and extensive induction and training, reinforced the practices vision and values and provided supportive pathways to new staff. There was strong team based working and an inter-disciplinary approach to delivering care in which decisions were made in the best interests of the patient. We saw how nurses referred patients to the GPs and visa versa to ensure the patients received the most appropriate clinical intervention. All the staff team had clearly defined roles and tasks within the practice and there were clear communication processes. Staff reported having received helpful training for inter-disciplinary team working as well as role specific training to enhance their roles.

Where complaints were received about staff or other aspects of the practice, we saw the practice manager spoke with those involved and offered them support to improve the services provided or staff performance. Performance was also discussed and reviewed at annual staff reviews. This ensured that performance was reviewed and services were improved for patients.

During the feedback session following our inspection, we highlighted some of the aspects of the practice which could be improved. We found the registered manager and another GP from the practice were receptive to our observation and in how they might consider small improvements to their service. They told us about constant reviews of the services they provided and about taking lead responsibilities within the clinical commissioning group and across Torbay. They also explained about the considerations they made as a consequence of the patient reference group and opening hours. These examples showed the practice was keen to learn and improve so their services to patients could be generally accepted as high quality.

Identification and management of risk

The practice had carried out risk assessments and had put in place a number of policies and protocols which would minimise the risks to patients, their staff and the practice. Risks assessments included, the environment, patient safety, infection control, ensuring vulnerable patients were protected, the management of medicines, staff recruitment, record keeping, health and safety and managing emergency situations. We also saw the practice had a clear and detailed business continuity and disaster recovery plan which covered the two surgeries it operated. These examples showed the practice had considered current daily and future risks.

Are services well-led?

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

We saw from staff training records that these policies formed part of newly recruited staff induction programmes. The staff we spoke with demonstrated a good knowledge of these policies through the discussions we had with them. The provider and practice manager told us that where policies or procedures were amended, these changes were communicated to staff informally and at staff meetings to ensure they were implemented as soon as possible. The practice manager told us they monitored adherence to these policies.

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

The practices mission statement sets out the key philosophies for the care and treatment of all patients, which ever population group they belong to. The practice worked hard to achieve quality patient care for older people, putting the patient first and aimed to build up strong long lasting relationships between patients and the clinical team. They aimed to maximise patient choice through being able to see and /or speak with their usual GP or any other GP in the practice, depending on the patients choice. Chilcote Surgery provided a wide range of expertise from specialist nurses to GPs with routinely updated specialist skills. In partnership with the Peninsula Medical School the practice helped support and develop medical students in their practice as part of their experience in general practice.

The practice provides a named accountable GP for all patients aged 75 and over, though like all patients, they are able to see any GP they wish. All patients including older people were given priority to care and treatment with GPs being accessible throughout the day with a focus on patients being able to see their chosen Doctor or Nurse. We saw staff were committed to keeping older patients as well as possible through the use of preventative measures and treating people as individuals. The practice aimed to empower patients to make their own decisions about their health.

Over 200 of the practice's most vulnerable patients including older people were admitted into the practices virtual hospital with each GP having a virtual ward of their own to manage. The wards comprised of patients with a certain condition for example patients with a diagnosis of dementia and other patients who GPs saw regularly. Monthly multidisciplinary meetings were held where each GP discussed patients with other team members to ensure their optimum care. Unplanned admissions and accident and emergency attendances for all virtual hospital patients and those in care homes were reviewed regularly with suggestions for improvement passed to the clinical commissioning group (CCG). Carers were involved where applicable. For example, letters to dementia patients informing them they were identified as vulnerable patients were sent to carers rather than patients to avoid unnecessary anxiety. The practice had a dementia support worker, who covered two of the Torquay practices, who spoke to the GPs about their services and how they can work together. The practice now refers older patients to the service when required.

A carer's support worker (CSW) was based at Chatto Road surgery 2 days per week and is available to provide support to carers registered at the practice including those who supported older people. Carers were seen at the practice or at home and were offered a health and wellbeing check as part of the CSW contact. Staff and GPs refer older patients to the CSW but patients could also contact the service directly. The CSW liaised with the hospital CSW when patients were discharged in order to ensure necessary support was in place on leaving hospital. In support of carers there were monthly meetings held with carers from another local practice called "Time Out". These meetings help extend the support offered to carers and the older people they supported.

The practice supported older people living in residential or nursing homes locally. Earlier this year the practice was involved in a medication review of residential homes, this included one local home where 20 patients were registered with the practice, some of whom had dementia. This involved sending in a pharmacist to complete a review of patients medicines and made recommendations which were followed up by the GPs. Other patients with a diagnosis of dementia also had their medicines reviewed at the same time as their annual health care reviews.

A leg ulcer service was provided in the practice by the practice's nurses and health care assistants which required high levels of clinical skills. Where there were housebound patients, the leg ulcer service was provided by the community nurses. Where need had been identified for patients living in a residential home, the practice had been instrumental in arranging for the tissue viability nurse to train staff at the home in order to provide the care required.

Medicines were regularly reviewed from a safety point of view by a pharmacist with whom the practice had a well established service. They work with the medicines

Older people

management team in connection with the prescribing local enhanced service (a local incentive scheme to ensure the most effective prescribing of medicines) to ensure better adherence and outcomes for older people.

For patients requiring end of life care and support, a palliative care meeting was held every month with the lead GP. The palliative register was updated as appropriate and the care needs of patients were reviewed.

Information folders were kept in both surgeries and were accessible to older people, they contained information to help patients improve their own health.

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's nursing team consisted of a lead nurse, nurse clinician, specialist nurse for four hours each week and respiratory nurse specialist for conditions such as asthma and chronic obstructive pulmonary disease (COPD). Four other nurses, two HCAs and a phlebotomist complete the team. Conditions supported by the nursing team included child immunisations, asthma, diabetes, falls prevention, weight management and phlebotomy (blood tests). These combined skills and knowledge in different areas complemented one another and ensured, as a team, they could provide a comprehensive service for patients. They worked effectively as a team with the lead nurse ensured they undertook all necessary training to keep their knowledge up-to-date.

The practice provides an additional specialist nurse service. The service comprises of two nurses with administrative support, and aims to complement and support the services already provided by the practice and community nurses. It provides a system of care for those patients with long-term illnesses who may have difficulty accessing services at the practice, and whose needs may be more appropriately met within their home environment. Conditions which required special attention included, coronary heart disease, heart problems, hypertension (high blood pressure), stroke and transient ischemic attack (TIA (mini stroke)), diabetes, asthma, chronic obstructive pulmonary disease, mental health problems, epilepsy, thyroid disease, cancer, arthritis, kidney and liver disease and falls. The specialist nurses visit housebound patients in their own homes or residential and nursing homes to monitor on-going treatment and medication, and offer appropriate support to both the patients and their carers.

Patients were treated and cared for as needs dictated and included the provision of health advice and signposting to support. All newly diagnosed diabetic patients were invited to attend a locally arranged group course in managing their diabetes. The GPs were also involved in the management of diabetes to ensure action was taken in response to any areas of concern. One of the nurses has had her knowledge and awareness of diabetes developed and promoted insulin initiation, a service which had been provided by the practice for some years without the need for referral to the hospital. An annual audit of the practices diabetic patients is performed with a multidisciplinary team meeting including the consultant diabetologist, to discuss action required for patients. Diabetic eye screening is also provided in the practice.

The practice had provided an active weight reduction clinic for many years. Audits carried out by the practice showed the clinic had helped patients to reduce weight where they followed the guidance and advice provided. Monitoring of weight also took place at routine appointments to ensure longer term benefits of weight loss were maintained.

The practices call and recall system invites patients with long term conditions to come to the practice in the month of their birth for a review. Patients with more than one long term condition were given a single appointment for their review. Three invitations were sent to patients to encourage participation. Patients could opt out at any time from the process each year or opt back in at any time.

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 held a weekly baby clinic at Chatto Surgery. The health visitor also had a child health clinic at the main practice. The nurses, health visitors and a GP saw mothers and their children for postnatal checks, childhood immunisations, developmental checks and any other related areas patients wanted to discuss. Children who had immunisations were given a 'goody' bag to encourage immunisations generally. Parents told us they appreciated the extra thought. Two of the administrative team ensured all children who required immunisations attended the practice for these by sending out reminders to parents.

For pregnant patients much of the care was provided by the midwife however the GPs were always available to see any patients if requested. Expectant mothers were encouraged to take folic acid. The midwives held clinics in the practice and were considered an integral part of the joined up service. This integration meant that if, for example, a patient complained about the attitude of a midwife, the practice arranged for the midwife's line manager to contact the patient to resolve the issue.

A tympanogram (an examination used to test the condition of the middle ear and mobility of the eardrum) was available in the practice to check for hearing problems such as glue ear (a condition where the middle ear fills with glue-like fluid instead of air) and identify indicators of deafness in babies and young children.

All staff at the practice were required to undertake safeguarding training on an annual basis to ensure awareness of abuse. Administrative staff received the basic level of training annually for adults and children, GPs and nursing staff had higher levels to maintain every 3 years, with a basic update undertaken in the intervening years. This helped ensure patient safety and appropriate referrals to local agencies where concerns were identified.

Children and pregnant women who are eligible for flu immunisation were invited to attend the practice for vaccination. Patients aged 18 and over had the choice of Saturday mornings and late afternoon appointments as well as when they attend practice for other appointments. Separate clinics were provided for those under 18 to allow more time. Following a review of last year's take-up in this age group, the practice had planned an all-day clinic for children during half-term this October with further dates as required for those unable to attend. This is a flu party with other practices in the Torbay area. The flu party will include entertainment for the children and was based on the success of a model led by a Penzance practice last year.

In 2010 the practice completed a toolkit for younger people called You're Welcome. This involved looking at the services provided by the practice through younger eyes and making changes to make it friendlier to this age group. The whole practice team was involved in the process to varying degrees and received accreditation in September 2010. The practice website section for younger people was developed as a result of this process. Two nurses and three GPs had undertaken additional sexual health training to enable them to offer the best possible service to young people.

The practice liaises with a range of other agencies regarding patients. A health visitor team was based at one practice enabling GPs and nursing staff to have regular communication with them. The midwives see patients at the practice and meet with the GPs on a regular basis regarding patients they wish to discuss.

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

For the majority of patients using the practice the successful implementation of a new patient appointment system had provided significant benefits over the previous appointment system. Access to GPs for advice or appointments had improved alongside extended practice opening times. We saw patients visiting the practice to see their GP before 8am and appointment slots were available in the evening up to 7pm. This helped patients from the working population. Patients were now usually able to get to see the doctor of their choice at a time which suited the patient and usually on the day they called. This had enhanced the continuity of care provided by the GPs.

The practice had reviewed their nursing team appointments following their patient survey. The practice was able to adjust the skill mix of the nursing team to provide a greater number of health care assistant and phlebotomy appointments. This review had enabled patients to see the most appropriate member of the team at times more suited to the working population.

Nurse appointments can be arranged to accommodate work commitments when required by patients. The practice's extended opening appointments on Monday evenings and early morning appointments from Tuesday to Friday at both locations, combined with the patient appointment system had provided greater flexibility for GP appointments. The practice also provided telephone consultations and fax prescriptions through to pharmacies both near patients work or a 24 hour pharmacy. Faxed prescriptions were also available to patients when they were working away from home for their convenience.

NHS health checks were offered to all patients aged 40-74 over a five year programme for a vascular risk assessment (Cardiovascular disease (CVD) is a general term that describes a disease of the heart or blood vessels, a risk assessment helps identify where this disease might occur).

International normalised ratio (INR) services (a blood test for people taking anti coagulation medicine), aortic aneurysm and retinal screening services are provided to the working population along with other population groups. The practice takes part in the national breast screening arrangements. The practice had received information that patient uptake figures for this year had dropped from 71% to 66.8% so were currently investigating why patients did not take an opportunity to have the screening. They were working on ways to promote the importance of taking this service up, for example through additional reminders.

The practice uses the hearcheck screening device for the identification of hearing problems. They also set up a pilot of teledermatology, a system used to support GPs in making the most appropriate clinical decisions, when it comes to referral into secondary care for dermatology. This service had been identified as an important tool in supporting dermatology learning and education. As a result of issues and learning points raised by the pilot, extra local education sessions had been organised and were well attended by GPs.

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

Chilcote Surgery holds the contract for Torbay to provide access to GP services for those who are homeless. Some of these patients were able to have accommodation at the Leonard Stocks centre, where clinics were held on Monday, Wednesday, Thursday and Friday. Other patients with no fixed address were also registered with the practice. All these patients could be seen at the Leonard Stocks centre on a walk-in basis or either of the practices by appointment. The practice nurse held a clinic at Leonard Stocks on Thursdays, whilst the GPs held clinics on the other days.

All services available to patients at the practice were available at the Leonard Stocks centre with particular attention paid to blood tests, smears and screening. A new practice initiative had been a nurse clinic at the Leonard Stocks centre provided by Shekinah mission (a Plymouth based service for homeless, addicted, socially excluded and/or otherwise vulnerable adults). Feedback from the centre indicates this approach was very beneficial for patients as the nurse built closer, more proactive relationships with the staff at the centre and they were now promoting the opportunity for the residents and the homeless to have a general health screen. The service had recently been reviewed by the clinical commissioning group (CCG) who identified the service as highly valued by patients and staff at the mission, with high levels of satisfaction.

Some of the GPs were involved in a co-creating health project whereby they attended a training course to improve consultation skills. The object was to encourage the patient to take greater responsibility for their own health. This approach was being applied to this population group alongside other patients.

The practice provided an additional specialist nurse service which was unique to the Torbay area. The service comprised of two nurses with administrative support, and aims to complement and support the services already provided by the practice and community nurses. It provides a system of care for those patients in vulnerable circumstances who may have difficulty accessing services at the practice, and whose needs may be more appropriately met within their home environment. Conditions which required special attention included, coronary heart disease, heart problems, hypertension (high blood pressure), stroke and transient ischemic attack (TIA (mini stroke)), diabetes, asthma, chronic obstructive pulmonary disease, mental health problems, epilepsy, thyroid disease, cancer, arthritis and kidney and liver disease. The specialist nurses visited housebound patients in their own homes or other locations.

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

We heard how the practice worked closely with the mental health service to refer patients to appropriate services including the mental health assessment teams, mental health and recovery teams and psychosis and recovery teams.

The practice explained how they had been concerned about the quality of local mental health services, particularly with access to the crisis team. Two years ago the practice collected patient evidence and compiled a number of reports to present to the new Chief Executive of Devon Partnership Trust including a letter from one of the GPs. The registered manager sits on the South Devon and Torbay Mental Health Redesign group and over the last two years had seen improvements in the quality and access of local mental health services. The practice now works with a more responsive crisis team and a responsive team at Waverley House Mental Health centre in Torquay which had a new consultant. The consultant provided consultations and full management plans to GPs at the practice promptly, this enabled better patient support.

Locally initiatives were in place for a mental health link worker for each practice to be initiated during the current year.

The practice had a targeted alcohol worker who attended the virtual ward meeting each month and provided a service to patients with alcohol related problems. The practice had the highest number of admissions for alcohol related problems in the clinical commissioning group (CCG), the targeted alcohol worker was helping reduce the admission rate.

The practice liaised with a responsive improving access to psychological therapies (IAPT) service which was used regularly and was appreciated by the patients who could self-refer if they so wish. The practice also maintained close links with the third (voluntary) sector such as a local charity which provided support to patients and to access opportunities to make changes, to use and develop skills, pursue aspirations and recover a good quality of life. The practice had also welcomed two trainee counsellors to work with patients and help the counsellors in their development.

The registered manager, who is also the main partner, completed nine months psychiatry training at Exeter and Torbay to inform services to patients. At present they are working on a proposal to link workers to all practices. The registered manager was also a member of the Torbay Adults Safeguarding Board 2012 to 2013 which had resulted in a more informed staff team and safer care and support for patients with a mental health problem.

There are various examples of where Chilcote Surgery had been a local innovator for people with mental health issues as well as other groups. A few to mention are, the local out of hours provider, set up by the registered manager in 1996, a weight loss programme, a Met Office pilot to reduce respiratory admissions, Tele-dermatology pilot to reduce the need for an outpatient referral, co-creating health project; Torquay North project to combine two surgeries of 27,000 patients with the health and social care team. The proposal went to the official journal of the European Union (OJEU) process but no site was able to be identified, morning triage with Torquay North health and social care team, setting up 8 to 8 surgery at Torbay Hospital and a medically unexplained symptoms clinic.