Cricketfield Surgery

Quality Report

Cricketfield Road
Newton Abbot
Devon
TQ12 2AS
Tel: 01626 208020
Website: www.cricketfieldsurgery.co.uk

Date of inspection visit: 27 May 2015
Date of publication: 30/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cricketfield Surgery on Wednesday 27 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. We found the practice was good for providing services for patients with long term conditions, families, children and young people, working age people (including those recently retired and students), People experiencing poor mental health (including people with dementia) and patients who are considered vulnerable. We found the practice was providing outstanding services for older people.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. The process of managing and learning from complaints and incidents was effective.
- Risks to patients were assessed and well managed. This included clinical risk and environmental risks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance including robust templates to guide staff.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they could make a same day appointment but sometimes found it hard to get through on the telephone and make advance appointments at a time that suited them and hard to

Summary of findings

get an appointment with a GP of choice. The practice were aware of this feedback and had introduced ways to improve the system and get further feedback from patients.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

The nursing team had been proactive in conducting clinical audits of the care they provided.

The GPs had used and developed the computer system to improve patient care by introducing prompts which triggered the use of National Institute for Health and Care Excellence (NICE) guideline templates. One example had been introduced following a significant event and included the use of one of the NICE templates for treatment and diagnosis of children and babies with high temperature. The GPs had developed the computer system to include the NICE traffic light assessment and automated referral letters. The system also prompted staff to give parents the NHS Sepsis assessment and management (SAM) leaflet and UK Sepsis leaflet which gives guidance and advice on sepsis. This template had been identified by NHS England as good practice and was being shared with other practices.

Care of older people was outstanding. This can be demonstrated by:

- The practice had been instrumental in the development of a '1 care home, 1 practice' model in Newton Abbot. The model allocated a designated GP who cared for the majority of residents in a named care home which meant the GP were able to offer regular review visits and develop strong relationships with the residents, managers and staff. The named GP for a care home for people with severe dementia often visited during quieter periods to give more time to the residents. She had given talks to relatives regarding the Mental Capacity Act and Best interest decisions.

  We spoke with two care home managers who were part of this initiative. One manager said they had found the GP and service 'extremely supportive' and 'beneficial' for residents with dementia who were able to see 'the same face' each time. Another care home manager described their relationship with the GP as 'absolutely wonderful' and said the residents were familiar to the GP and that the GPs approach to care of the elderly was 'second to none'.

- The practice were taking part in a pilot project led by Age UK Devon whereby a health and wellbeing worker was based within the practice to work with their 'pre-frail' population, using guided conversations and signposting to voluntary sector services to help improve patients sense of health and wellbeing.

- One of the GPs had developed and ran the Newton Abbot Frailty Service, a multi-disciplinary team providing intensive input for particularly frail and vulnerable patients in the locality to enable them to remain at home. The service offered both pro-active and emergency input similar to that offered in the monthly multidisciplinary team meetings but at a much more intensive level. Other GPs in the practice frequently referred patients to this service.

- The practice were also actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover on the weekend for the top 2% most frail patients. The GPs had collaborated so that all the local GPs involved in this have access to the other practice's computer databases, so were much more informed about the patients they were seeing, than Devon Doctors (the out of hours service provider) would be.

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

The provider should:

Introduce a recruitment policy for staff to follow when recruiting clinical and non-clinical staff.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. Medicines were well managed and there were enough skilled staff to keep patients safe.

There were enough staff on duty and the two practice managers followed a set process when recruiting clinical and non-clinical staff. However, there was no recruitment policy that set out these standards to follow in the absence of the practice managers.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback and data showed that patients rated the practice well for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Information for patients about the services available was easy to understand and accessible.

We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified and had demonstrated this clearly when caring for older people.

Patients said they did not always find it easy to make an appointment with a named GP but the practice were responding to this by introducing additional appointments and recruiting staff. Patients could speak with a GP or access urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

There were systems in place to monitor and improve quality and identify risk.

The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was in its infancy but fully supported by the practice.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Outstanding ☆

Older people

All patients aged 75 and over had been informed that they had been given a named GP who managed all the patient's paperwork and medication requests. Patients also had a choice of which GP to see and the practice had, where appropriate, changed the named GP to reflect patient preference.

Pneumococcal, shingles and influenza vaccines were offered to all eligible patients and were promoted through posters in the practice, the waiting room screens, notes on patient prescriptions and by direct patient contact (text, email or post depending on methods chosen by the patients). Vaccinations for housebound patients were provided by the community nursing team.

Home visits were offered for patients who were unable to attend the practice for both emergency care and pro-active chronic disease management. The practice had a designated visiting GP each day which allowed patients to be seen earlier in the day to avoid unnecessary admission to hospital by getting health care intervention in place. Having a nominated visiting GP also freed up space in the day to arrange visits for end of life and chronic disease patients who were well known to a particular GP thus improving relationships with patients and their families.

The practice had been instrumental in the development of a 'one care home, one practice' model in Newton Abbot. The model allocated a designated GP who cared for the majority of residents in a care home which meant the GP were able to offer regular review visits and develop strong relationships with the residents, managers and staff. We spoke with two care home managers. One care home found the GP and service 'extremely supportive' and 'beneficial' for residents with dementia who were able to see 'the same face' each time. Another care home manager described their relationship with the GP as 'absolutely wonderful' and said the residents were familiar to the GP and that the GPs approach to care of the elderly was 'second to none'.

The practice were easily accessible with the majority of consultations being provided on the ground floor. There was a stair lift providing access to the first floor, a wheelchair and some raised seats in the waiting room available to assist patients with mobility issues.

The practice held a monthly multidisciplinary team meeting with community nurses, matrons, therapists, palliative care nurses and social workers. The MDT meeting was an opportunity to discuss

Summary of findings

patients identified as the 2% most vulnerable, those at risk of admission to hospital and those receiving palliative care and to be able to provide co-ordinated multidisciplinary care for these patients.

The practice were taking part in a pilot project led by Age UK Devon whereby a Age UK health and wellbeing worker was based within the practice to work with 'pre-frail' population using conversations and signposting to voluntary sector services to help improve patients sense of health and wellbeing.

One of the GPs had developed and ran the Newton Abbot Frailty Service, a multi-disciplinary team providing intensive input for particularly frail and vulnerable patients in the locality. The service offered both pro-active and emergency input similar to that offered in the monthly multidisciplinary team meetings but at a much more intensive level. Other GPs in the practice frequently referred patients to this service.

The practice were also actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover on the weekend for the top 2% most frail patients. The GPs had collaborated so that all of the local GPs involved in this had access to the other practice's computer databases, so we were much more informed about the patients they were seeing, than Devon Doctors (the out of hours service provider) would be.

People with long term conditions

Good

The practice maintained a register of patients with long term conditions such as diabetes, heart failure, asthma, chronic obstructive pulmonary disease (COPD), hypertension, cerebrovascular disease and ischaemic heart disease. Specialist nurse-led clinics were available for these patients and a recall system was in place to ensure that patients were reviewed at an appropriate frequency (for example, annually for ischaemic heart disease and 6 monthly for diabetes). The nurses attended educational updates to make sure their lead role knowledge and skills were up to date.

The practice ran a vascular clinic for patients with hypertension, cerebrovascular disease, peripheral vascular disease or chronic renal impairment where they were seen by the health care assistant. The consultation was driven by an automated protocol based on national guidelines. Should they have any issues that require a more experienced review they were seen straight after the appointment by a senior nurse or GP saving them having to make another appointment at a later date.

Summary of findings

For more complex patients the practice had designated GPs who had an interest in particular chronic diseases and whose advice could be sought or who would review the patients. Practice nurses and the GPs had a regular meeting with the diabetes nurses and GP to discuss more complex patients. These meetings were held monthly giving opportunity to review treatment plans, liaise with community nurses and refer on to primary care as appropriate.

Where patients with long term conditions were housebound, the practice were supported by a community matron who was able to support the patient and assess their condition in their own home.

Families, children and young people

Good

Ante-natal care was provided by a team of midwives who worked with the practice. Midwives held clinics at the practice and had access to the practice computer system and could speak with the duty GP should the need arise.

A routine six week post-partum appointment was offered to all patients with their registered GP to discuss both the mother's health and wellbeing and the infants and to perform the required six week check.

The practice had a well organised immunisation programme, proactively inviting families to attend and alerting the registered GP to any families who don't take up this programme.

The practice had an automatic alert on the clinical system for all children on a child protection plan or who were classified as a child in need and cross-referenced the information with siblings and parents.

The practice had developed an automated assessment protocol with the clinical system that enabled the practice to assess unwell children against the National Institute for Health and Care Excellence (NICE) traffic light system and provide appropriate advice, safety netting and referral letter based on clinical findings. This protocol was being trialled in other practices in the region with interest from NHS England to make it available nationally.

There were well organised baby and child immunisation programmes available.

The local health visitor was encouraged to attend the monthly multidisciplinary team meeting to discuss particular families that they or the GPs were concerned about.

Summary of findings

Patients had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. Several GPs were experienced in fitting implants and coils and staff were developing a more focused contraceptive and women's health service within the practice.

Working age people (including those recently retired and students)

Good

To help working-aged patients the practice offered a variety of appointments to try and avoid unnecessary time off work. The practice offered email and telephone consultations and a once weekly evening surgery for both GP and nursing appointments and were planning evening phlebotomy services.

Patients were able to book appointments, request medication and contact the practice or their GP via the practice website. Advanced appointments were available up to 4 weeks in advance to assist patients who do not have the flexibility to phone in the morning for an appointment that day.

Following feedback from patients the practice had recently started offering a daily lunch time GP surgery to students and the working population so as to minimise the disruption to their working day.

The practice use an SMS reminder service for appointments and also use SMS and email to contact patients regarding health promotions, chronic disease appointments, test results and so on.

The practice worked with local travel clinics and pharmacists who provide extensive travel assessment and private vaccinations. Cricketfield administer NHS vaccinations and general travel health advice.

NHS health checks were offered to patients between the ages of 40 and 74 as well as smoking cessation services and opportunistic lifestyle advice and appropriate screening such as cardiovascular risk, cholesterol blood pressure and prostate screening.

Patients were able to collect their prescription at a place of their choice. The practice used an electronic prescribing system which allowed a rapid turnaround of prescription requests.

People whose circumstances may make them vulnerable

Good

Although the practice had a very small number of patients who were not fluent in English, staff had access to, and encourage the use of, language line telephone translation services at the practice. The practice also had the facilities to arrange a sign language interpreter to be present for patients with hearing impairment.

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with

their carer involved in the discussion if appropriate. The practice contacted the patients and / or the carers inviting them to attend for a longer than usual appointment allowing the time for effective communication and assessment.

The practice looked after patients in a learning disabilities residential home and arranged annual assessment to be carried out in the home by the same GP each year to allow consistency of relationships.

The practice looked after a number of patients with alcohol related health issues and provided on going support, including referral to a local alcohol support service. One of the GPs was also able to provide a community detox programme for appropriate patients.

People experiencing poor mental health (including people with dementia)

Good

The practice had a designated mental health GP lead and a computer generated reminders system for mental health reviews. Templates were completed for medication reviews and to request necessary blood tests for monitoring drug dosage and effects.

The practice had direct access to the local mental health team for advice and could refer patients to the outpatient's services in the locality. The GPs referred patients to the local Recovery and Integration Service. (Devon-wide adult substance misuse service, working with people with alcohol and drug problems).

The practice accessed and requested advice from the older people's mental health team based at the local acute trust.

The practice had a large number of patients at a supported home for patients transitioning from inpatient mental health care to the community. The GPs liaised with the home regarding the patient medication and follow up as requested by the psychiatrists.

The practice were able to refer patients to a counsellor in the town. The counsellor reported regularly on waiting times and her caseload and discuss patients directly with the practice if appropriate.

The practice looked after a nursing home for patients with advanced dementia. The GP responsible for patient care performed regular pro-active visits as well as emergency visits and had built an excellent relationship with the staff at the home to ensure the home and practice could deliver the best care possible for these patients.

To improve diagnosis rates of dementia, one of the community nurses had been screening patients in the local care homes who

displayed possible cognitive impairment but do not have a diagnosis of dementia. Any patients who had demonstrated possible dementia on the screening tool were referred back to their GP for further assessment.

Patients with dementia were reviewed annually to assess all aspects of their health and wellbeing. An assessment of their capacity was made in line with the Mental Capacity Act, and those who lacked capacity for any decision making process were identified in the clinical notes and further action taken as necessary.

Summary of findings

What people who use the service say

We spoke with 18 patients during our inspection and with a member of the patient participation group.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 40 comment cards, 28 of which contained positive comments. There were negative comments on 12 of the comment cards, these all related to getting through on the telephone and access to appointments.

Comment cards with positive comments were detailed and stated that patients appreciated the helpful staff, caring and respectful service provided, the clean and tidy building and praised the GPs, reception staff and nurses. Many staff were named as giving extra care and attention. Patients referred to being satisfied, reassured and grateful for the attention and care they received.

These positive findings were reflected during our conversations with the 18 patients we spoke with and from looking at the practice's 61 friends and family test results from December 2014 to March 2015 and from the practice patient survey from March 2014. The feedback from patients about the care and treatment was consistently good. Patients told us about their experiences of care and praised the level of individual care and support they received at the practice from all staff. Positive comments showed that patients thought the service was good and that staff were caring and professional. Patients told us that the GPs and nursing staff were excellent. Of the 61 friends and family test results we saw 38 patients said they were extremely likely or likely to recommend the practice. There were 10 other results which stated patients were neither likely nor unlikely. Eleven patients said they would be extremely unlikely to recommend the practice. The reasons stated were getting through on the telephone and poor appointment choice. The comment cards we received and patients we spoke with on the day of inspection reflected these findings. The practice had noted this feedback and were in the process of introducing changes. These included staffing changes, introduction of additional appointments and further consultation with patients. Details of these are included within this report.

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

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients said they found it easy to get repeat prescriptions processed.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a recruitment policy for staff to follow when recruiting clinical and non-clinical staff.

Outstanding practice

The nursing team had been proactive in conducting clinical audits of the care they provided.

The GPs had used and developed the computer system to improve patient care by introducing prompts which triggered the use of National Institute for Health and Care

Summary of findings

Excellence (NICE) guideline templates. One example had been introduced following a significant event and included the use of one of the NICE templates for treatment and diagnosis of children and babies with high temperature. The GPs had developed the computer system to include the NICE traffic light assessment and automated referral letters. The system also prompted staff to give parents the NHS Sepsis assessment and management (SAM) leaflet and UK Sepsis leaflet which gives guidance and advice on sepsis. This template had been identified by NHS England as good practice and was being shared with other practices.

The practice had been instrumental in the development of a 'one care home, one practice' model in Newton Abbot. The model allocated a designated GP who cared for the majority of residents in a care home which meant the GP was able to offer regular review visits and develop strong relationships with the residents, managers and staff. The named GP for a care home for people with severe dementia often visited during quieter periods to give more time to the residents. She had given talks to relatives regarding the Mental Capacity Act and Best interest decisions. One care home found the GP and service 'extremely supportive' and 'beneficial' for residents with dementia who were able to see 'the same face' each time. Another care home manager described their relationship with the GP as 'absolutely wonderful' and said the residents were familiar to the GP and that the GPs approach to care of the elderly was 'second to none'.

The practice were taking part in a pilot project led by Age UK Devon whereby a health and wellbeing worker was based within the practice to work with their 'pre-frail' population, using guided conversations and signposting to voluntary sector services to help improve patients sense of health and wellbeing. One of the GPs had developed and ran the Newton Abbot Frailty Service, a multi-disciplinary team providing intensive input for particularly frail and vulnerable patients in the locality to enable them to remain at home. The service offered both pro-active and emergency input similar to that offered in the monthly multidisciplinary team meetings but at a much more intensive level. Other GPs in the practice frequently referred patients to this service.

The practice were also actively involved in the locality '8 to 8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover during weekends for the top 2% most frail patients. The GPs worked collaboratively so that all the local GPs involved had access to the computer records, so were much more informed about the patients they were seeing.

Cricketfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Cricketfield Surgery

Cricketfield Surgery was inspected on Wednesday 27 May 2015. This was a comprehensive inspection.

The main practice is situated in the Devon town of Newton Abbot. The practice provides a primary medical service to approximately 10,500 patients of a diverse age group but with a higher percentage of older people. The practice are a training practice for doctors who are training to become GPs.

There was a team of six GP partners and two salaried GPs within the organisation. Partners hold managerial and financial responsibility for running the business. There were four male and four female GPs. The team were supported by two practice managers, three practice nurses, four health care assistants and 14 administration staff.

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

The practice is open from Monday to Friday, between the hours of 8.00am and 6.00pm. Appointments are available between these times. Tuesday evening routine appointments until 8.30pm were available for people who were unable to access appointments during normal opening times.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service. However, The practice were actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover on the weekend for the top 2% most frail patients.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Mothers, babies, children and young people

• The working-age population and those recently retired

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

• People experiencing poor mental health

Before conducting our announced inspection of Cricketfield Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local NEW Devon Clinical Commissioning Group.

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

We carried out our announced visit on Wednesday 27 May 2015. We spoke with 18 patients, four GPs, two practice nurses, a health care assistant and members of the management, reception and administration team. We collected 40 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

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

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, nursing staff said they had completed a reporting form once an event had been identified. Staff explained they had been supported when involved in this process and that any learning was shared in an open supportive way.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 32 significant events that had occurred during the last two years. We tracked five of these incidents and saw records were completed in a comprehensive and timely manner. We noted that the practice used the process for significant events and potentially significant events as a way of improving care and treatment and to reduce the risk of reoccurrence and used the system to inform other agencies where learning could be shared. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff and external agencies. For example, a significant event involving the practice and other agencies had resulted in the practice introducing computer system which involved National Institute for Health and Care Excellence (NICE) recommendations to prompt staff to effectively assess children with high fever. The system also generated referral letters to hospital and an advice leaflet to be given to parents. The system had been recognised by NHS England with a plan to roll out nationally to other GP practices. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by email, instant message and through staff meetings. Staff we spoke with were able to give examples of recent alerts but noted that these had not been relevant to the care they were responsible for but had provoked discussion.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns, how to report to the safeguarding leads and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and level 3 training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or at risk children. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in

monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

There was a chaperone policy, and posters which were visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Records of these checks were kept electronically. We noted that fridges did not have systems in place to prevent the socket to become removed or switched off.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. The practice employed a member of staff with experience in the management of medicines. They manage the repeat prescriptions and monitor medicines following patient discharge from hospital ensuring all changes in medicines are communicated to the GPs and nursing team.

There was a system in place for the management of patients taking high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. Nursing staff had conducted an audit on the management of INR. INR is a test to make sure the level of anticoagulant medicines are effective in preventing unwanted blood clots from forming. The nursing team had looked at how patients understood their INR results. Nursing staff had used the computer system to identify housebound patients and patients with memory loss or signs of dementia who may be at risk of forgetting to have a check performed. Once identified these 31 patients had been reviewed by the GPs and 11 had been prescribed alternative oral medication which did not rely on frequent INR tests.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated within the last year and had been signed and agreed by the lead GP, lead nurse and nurses using the directives. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed. She explained she only prescribed within her scope of practice

The practice used electronic prescribing and had established a service for patients to pick up their dispensed prescriptions at locations of the patients choice and had systems in place to monitor how these medicines were

collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required. Patients said this process worked well.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were clinical cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An extensive infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There were also posters displayed and a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The lead nurse was the lead for infection control. She had undertaken further training to enable her to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of clinical meetings showed that the findings of the audits were discussed. For example, the most recent audit had resulted in a change of uniform policy and the introduction of clinical cleaning wipes.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. For example an external organisation had been contracted to manage gas, air conditioning, intruder alarm fire alarm, fire extinguishers, etc. Regular inspections and water temperature testing. Schedules seen to show regular inspections and maintenance for legionella had been performed carried out in February 2014. The practice had also carried out a fire risk assessment in 2015. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was calibrated, tested and maintained regularly by the local acute hospital medical equipment department. We saw equipment maintenance logs and other records that confirmed this had taken place in September 2014. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was last done in Feb 2013 and had been scheduled to be done again in June 2015.

Staffing and recruitment

The two practice managers followed a set process when recruiting clinical and non-clinical staff. However, there was no recruitment policy that set out these standards to follow in the absence of the practice managers. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and systems to ensure staff are registered with the appropriate professional body. The practice had introduced a change in policy to ensure that all staff had the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual

Good

Are services safe?

staffing levels and skill mix met planned staffing requirements. There were recruitment procedures in place to replace staff vacancies and were currently in the process of recruiting clinical staff.

Monitoring safety and responding to risk

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

Identified risks were included on a risk assessment which was carried out by the operations manager. Examples seen included health and safety, fire, lone working, use of electrical appliances, display screen equipment safety, needle stick injury, COSHH (control of substances hazardous to health), manual handling, use of stair lift, and vaccine handling. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support and this was usually offered on the 'target days' which were held four times a day. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. Staff said a recent patient collapse had been managed successfully.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We saw records to show these checks were performed regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was due for review in July 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff said any changes in these guidelines were communicated by email and within clinical meetings. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. The GPs had used and developed the computer system to improve patient care by introducing prompts which triggered the use of NICE guideline templates. One example had been introduced following a significant event and included the use of one of the NICE templates for treatment and diagnosis of children and babies with high temperature. The GPs had developed the computer system to include the traffic light assessment and automated referral letters. The system also prompted staff to give parents the NHS Sepsis assessment and management (SAM) leaflet and UK Sepsis leaflet which gives guidance and advice sepsis. This template had been identified by NHS England as good practice and was being shared with other practices.

Other templates being used at the practice included guidance for contraception, falls assessment, palliative care and minor surgery.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required. Staff also explained that patients were invited to attend a 'one stop' clinic to have screening for their long term conditions. These clinics were led by the health care assistants and included blood tests, blood pressure checks, health promotion and other tests as required.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of diabetes and respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. This included a member of staff who specifically looked at medicines changes and made sure these changes were implemented and recorded.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The nursing team had been proactive in undertaking clinical audits to demonstrate the care being given was effective. We saw summaries of 13 clinical audits performed by nursing staff. Six of these were routine monthly audits to ensure testing machines are functioning correctly. However, other audits had checked to see if patients were receiving the care and treatment then needed. For example, to see if patients identified in the asthma audit had a current asthma action plan. Nursing staff explained this was done to empower patients and improve their asthma control.

Good

Are services effective?

(for example, treatment is effective)

The practice also showed us six clinical audits that had been undertaken in the last 18 months. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one audit had resulted in education sessions on the appropriate antibiotic prescribing and ensured GPs were using the prescribing formulary, microbiology advice and mobile app available to prompt appropriate medicines use. Re audit showed a drop in inappropriate use of antibiotics.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of asthma inhalers which had resulted in more accurate monitoring of inhaler use and the introduction of a strategy for stepping down asthma management as appropriate at routine reviews.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 96% of the total QOF target in 2014, which was above the national average. Specific examples to demonstrate this included:

- Performance for diabetes related indicators were better than the national average. For example 100% of the 531 patients on the diabetic register had been referred to a structured education programme and 87% had received a medication review so far this year.
- The percentage of patients with hypertension having regular blood pressure tests was 79.27% which was similar to the national average
- 100% of patients with mental health illnesses had received a medicines and health review.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

The practice staff checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. Patients said they received prompts and requests when medicines reviews were needed.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. The 'one care home, one practice' model which allocated a designated GP to a care home also meant the GP was able to develop relationships with patients which then influenced end of life care planning. We spoke with two care home managers who said this meant that the GPs were familiar with the patients and had improved mutual respect and communication with staff. The practice were also actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover on the weekend for the top 2% most frail patients. The GPs had collaborated so that all of the local GPs involved in this had access to the other practice's computer databases, so were much more informed about the patients they were seeing, than Devon Doctors (the out of hours service provider) would be.

One of the GPs had developed and ran the Newton Abbot Frailty Service, a multi-disciplinary team providing intensive input for particularly frail and vulnerable patients in the locality. The service offered both pro-active and emergency input similar to that offered in the monthly multidisciplinary team meetings but at a much more intensive level which aimed to keep patients out of hospital. Other GPs in the practice frequently referred patients to this service.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs. All GPs had lead roles to share the leadership responsibilities. All GPs were up to date with

Good

Are services effective?

(for example, treatment is effective)

their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example practice nurses had been able to attend extended training to update their knowledge in diabetes. The lead nurse had also connected with other practice nurses in the area to share learning opportunities and experiences. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of immunisations, ear syringing, would care, travel vaccines, and cervical cytology. Those with extended roles, including seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. The practice had recognised the skills of health care assistants (HCA) at the practice and provided further education and training for them to take on additional roles and health screening. For example one of the HCAs performed ear syringing and wound dressings.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those with complex needs. They received blood test results, X ray results, and letters, discharge summaries and reports from the local hospital, out-of-hours GP services and the 111 service, both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising. In the event of GPs being absent a buddy system was used to ensure these results were acted upon. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There was one instance identified within the last year of a referral not being followed up. This had led to the introduction of the buddy system.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, the top 2% of vulnerable patients, patients with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice were also actively involved in the locality '8-8 initiative', whereby local Newton Abbot GPs had been providing out of hours cover on the weekend for the top 2% most frail patients. The GPs had collaborated so that all of the local GPs involved in this have access to the other practice's computer databases, so they were much more informed about the patients we were seeing, than Devon Doctors (the out of hours service provider) would be.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. Many hospital referral letters were generated from NICE guideline templates incorporated in the computer system.

Good

Are services effective?

(for example, treatment is effective)

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. One GP had also provided information on the MCA and best interest decisions for relatives and staff in a care home for people with advanced dementia.

Patients with a learning disability and those with dementia were supported to make decisions through the use of consultation and care plans, which they were involved in agreeing with carer support if appropriate. These care plans were reviewed annually at the health care review, or more frequently if changes in clinical circumstances dictated it.

Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all childhood immunisations and joint injection procedures. The practice had computer templates which were automatically generated for these procedures. Where formal templates were not used, staff entered details of the discussion about the relevant risks, benefits and possible complications of the procedure. For example for contraceptive procedures.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice had identified the percentage of chlamydia screening had been lower than expected and had introduced changes which had started to improve the outcomes. For example, placing the kits close to the toilets for privacy.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 449 of patients in this age group took up the offer of the health check and 89% of patients had had screening for Breast Cancer. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified 1646 patients as smokers over the age of 16 and actively offered nurse-led smoking cessation clinics to 79% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was good. For example they had screened over 500 women in the past year. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A member of staff had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was similar for the majority of immunisations where comparative data was available. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 92% to 99% and five year olds from 92.2% to 100%. These were above CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey from March 2014, data from the practice survey and from a survey of 61 patients undertaken as part of the friends and family test.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the practice patient survey showed that 98% of the 54 respondents had confidence in the clinicians they saw and 97% felt they had been treated with dignity and respect.

These positive findings were reflected within the 61 friends and family test results from December 2014 to March 2015 and within the 40 comment cards we received. The feedback from patients about the care and treatment was consistently good. Any negative comments we saw related to getting through on the telephone and access to appointments. Patients told us about their experiences of care and praised the level of individual care and support they received at the practice from all staff. Positive comments showed that patients thought the service was good and that staff were caring and professional. Patients told us that the GPs and nursing staff were excellent. Of the 61 friends and family test results we saw 38 patients said they were extremely likely or likely to recommend the practice. There were 10 other results which stated patients were neither likely nor unlikely. The practice survey also asked the question whether patients would recommend the practice. 91% of patients said they would recommend the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with either of the practice managers.

We spoke with two care home managers who said the two GPs who visited the care homes had been popular with residents. One manager said the GP showed 'an absolutely wonderful approach to the elderly.'

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 98% of the respondents said they understood what was said to them. Patients we spoke with said they had been involved in discussions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of inspection were positive about the emotional support provided by the practice and said they received kind, caring, and friendly service. The survey findings supported these opinions. Patients also told us the care and treatment they received was prompt and efficient.

Patients told us they were provided with enough information. Notices in the patient waiting room, on the TV

Good

Are services caring?

screen and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation if necessary. The practice also sent a sympathy card to a spouse or family member of patients who had suffered bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had recognised it had a higher than average elderly population and had introduced systems and worked with other agencies to make sure the needs of the elderly were met. For example, a designated visiting GP each day which allowed older patients to be seen earlier in the day to avoid unnecessary admission to hospital. Other examples included the 'one care home, one practice' model in Newton Abbot and involvement in the Newton Abbot Frailty Service for particularly frail and vulnerable patients in the locality.

The practice were also taking part in a pilot project led by Age UK Devon whereby a health and wellbeing worker were based within the practice to work with 'pre-frail' population using guided conversations and signposting to voluntary sector services to help improve patients sense of health and wellbeing.

The practice had also recognised that patients had not been happy with the appointment system and wanted more feedback. As a result they were promoting the patient participation group and had a meeting to discuss future plans.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The practice looked after a number of patients with alcohol related health issues and provided ongoing support, including referral to a local alcohol support service. One of the GPs was also able to provide a community detox programme for appropriate patients. Patients transitioning from inpatient mental health care to the community were also supported by the GPs and health care professionals.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. There were chairs of various heights in the waiting room but no chairs with arms which would help older patients or those with mobility issues stand from a seating position.

Access to the service

The practice was open and appointments available from 8am to 6pmMonday to Friday and until 8.30pm on Tuesday evenings. Patients could book appointments three weeks in advance and also book on the same day appointments.

Patients we spoke with were not all aware of the appointment choices and times. Comprehensive information was available to patients about appointments on the practice website and in the patient information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes. The practice had been instrumental in the development of a 'one care home, one practice' model in Newton Abbot. The model allocated a designated GP who

Good

Are services responsive to people's needs?

(for example, to feedback?)

cared for the majority of residents in a care home which meant the GP were able to offer regular review visits and develop strong relationships with the residents, managers and staff.

We received 40 completed comment cards. Twelve of these contained negative feedback about accessing an appointment at the practice. The three themes emerged. These included three comments about getting through on the telephone, nine comments included the difficulty in getting an appointment and three comments about the suitability of appointment time for working people and parents who were unable to contact the practice during the school run. There was one comment about dissatisfaction of not being able to see the GP of choice. Patient survey and friends and family results also highlighted patient dissatisfaction with the appointment system.

The practice staff said they were aware of this feedback and had introduced changes and were looking at ways of further improving patient access. For example, the practice had introduced lunch time appointments since February and the ability to book appointments online. The practice had planned an open evening for patients in June to give patients an opportunity to feed back with ideas of how other improvements may be made.

The practice were also in the process of recruiting another GP and nurse to increase appointments. The practice were also signed up to new initiatives to provide a Pharmacist to help with medicine reviews which would allow GPs to see more patients. The GPs also explained about the future use of technology to reduce the pressure on staff.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Posters were displayed in the waiting room and information was also found on the website and in the patient information leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 38 formal and informal complaints received in the last two years and found that these had been satisfactorily handled, dealt with in a timely way, with openness and transparency.

The practice had a system in place which looked at complaints and analysed to monitor any trends. The practice had reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. Staff we spoke with said they had four 'target days' a year and regular team meetings where services are discussed. We found details of the aims and objectives listed in the statement of purpose and found that some staff were aware of this. Staff all knew and understood they were part of a team which aimed to provide a friendly and high quality service and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff explained they were emailed or informed at staff meetings when policies were updated. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure amongst the GPs with clearly defined responsibilities. For example safeguarding, IT, education, staff liaison, and commissioning. GPs also took a lead on clinical subjects including mental health, older people and vascular disease. The lead nurse was lead nurse for infection control. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example where medicines needed to be changed or reviewed because of cost, safety or effectiveness. The practice managers and GPs used evidence from other data from sources, including incidents and complaints to identify areas where improvements could be made.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed with minutes kept for staff to refer to if they were unable to attend the meetings. Staff explained that communication was very good at the practice and that the structured programme of formal meetings, effective email system and face to face meetings helped with this.

The practice manager was responsible for human resource procedures and noted there was no policy for recruitment. However, there were a number of policies in place to support staff. For example induction policy and whistleblowing policy which was also available to all staff electronically on any computer within the practice.

Leadership, openness and transparency

The GP partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from a meetings schedule that there were well structured team meetings held regularly. Staff said communication also happened informally between these meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held four days per year. Staff said they felt respected, valued and supported, particularly by the GPs in the practice.

Seeking and acting on feedback from patients, public and staff

The practice valued the opinions from patients and used had gathered feedback from patients through the surveys and complaints received and had reviewed the findings to

Are services well-led?

Good

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

actively encourage patients to be involved in shaping the service delivered at the practice. For example, the practice had set up a new patient participation group (PPG) following the previous group stepping down. One of the GPs had been nominated as lead for the PPG and had included a letter of invitation in the patient newsletter to attend a patient open evening for patients to give feedback on the service.

The practice had also gathered feedback from staff through staff away days, meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues, the GPs and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where external guest speakers and trainers attended. The practice nurses also worked with other practices to access and provide training and support. For example, the practice held target days where all staff have access to training and outside speakers. Where relevant other practice nurses were invited to attend these sessions.

The practice managers also received support where needed and were being formally mentored by other practice managers in the area.