Bovey Tracey and Chudleigh Practice

Quality Report

Riverside Surgery
Le Molay-Littry Way
Bovey Tracey
Devon
TQ13 9QP
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Outstanding
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 Bovey Tracey and Chudleigh Practice on Wednesday 15 April 2015.

Overall the practice is rated as good.

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

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. There was a culture of learning from such incidents.
- Clinical and environmental risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Complaints were well managed. Information about how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP and said that there was continuity of care. Urgent appointments were available the same day.
- The practice was well maintained and equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of **Outstanding** practice:

Summary of findings

The practice is outstanding in providing effective care. This can be demonstrated by the development of community working to enhance patient well being.

- The GPs at the practice had been instrumental in supporting and setting up two community groups of volunteers called Bovey Community Care and Riverside befrienders. One of the GPs remains as a Trustee and supports where required. The practice works closely with both organisations which are now self-sufficient. The practice take the bookings for transport with Riverside Befrienders and offer general help and support when it is needed for administration, advertising recruiting etc. Last year the befrienders carried out 967 journeys with patients. The Bovey Community Care group started offering support in June 2013, have over 40 volunteers, and received over 100 referrals for social support. The GPs at the practice facilitated the group to introduce hospital discharge support in November 2014 and attend hospital discharge meetings with representatives from the group. The group have supported eight patients after their discharge from local hospitals. At present the group were actively supporting 28 clients in the community, with befriending, help with shopping and prescription collection, dog walking, carer relief, dementia support, trips out of the house, specific support for the visually impaired, signposting, support to engage with local social groups, help with applying for benefits, and the preparation of nutritious meals. For example, One patient with dementia was supported by a volunteer who takes the patient out for long walks, and spends time engaging in which were once the patient's hobbies. The examples we were given showed a positive impact on the patients well-being and demonstrated support and respite for the carers.

The practice had well organised processes in place and the administration and management of the practice was outstanding in that documentation, policies and procedures were of a very high standard. For example, personnel files from 20 years ago contained everything that would be expected with changes of legislation in recent years and were well organised and structured. Practice policies were comprehensive and complete and had been produced by the practice rather than being copied from templates or other practices.

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

Action the provider SHOULD take to improve:

- Ensure patients are aware of the chaperone service.
- Ensure staff have access to appropriate training in the Mental Capacity Act 2005

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. There was a culture of learning from incidents. 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. Recruitment processes were robust and there were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Data showed patient outcomes for health promotion and screening were at or above average for the locality. The practice were consistently performing well in particular with childhood and seasonal flu vaccines, cervical screening and smoking cessation.

Staff referred to guidance from National Institute for Health and Care Excellence and used this guidance routinely. Patient's needs were assessed and care was effectively and efficiently planned and delivered in line with current legislation. This included the management of patients with long term conditions and promoting good health. This also included organisation of staff rotas to provide clinics that ran concurrently with experienced and trained staff with supernumerary support from a GP.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams and voluntary groups which had a positive impact on patient experience.

The GPs at the practice had been instrumental in setting up and supporting two community groups of volunteers called Bovey Community Care and Riverside Befrienders. One of the GPs remains as a Trustee and supports where required. The practice works closely with both organisations which are now self-sufficient, who provide transport services and hospital discharge support for their patients.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

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

Are services well-led?

Good

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

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

The management team at the practice were knowledgeable, committed and caring. This had resulted in additional systems being introduced and clearly maintained to support the clinical practice.

Summary of findings

The practice had well organised processes in place and the administration and management of the practice was outstanding in that documentation, policies and procedures were of a high standard.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Pneumococcal vaccination and shingles vaccinations were provided at the practice for older people.

The practice maintained a register of the top 2% of 'at risk' patients and made sure each person had a care plan which was reviewed every three months.

The practice worked to enable patients to remain at home, to help avoid unplanned admission to hospital. They worked with other health care professionals to provide joint working. Unplanned admissions to hospital were reviewed monthly to identify any gaps in care and treatment or areas for service improvement. The practice worked closely with the community matron to follow up patients discharged from hospital to ensure all their needs were met. The practice had access to a rapid response service and single point of access for referral of patients to specialist services.

The practice provided a service to patients living in four local care homes and worked with the staff to ensure new patients had a full health and medication reviews and treatment escalation plans in place.

There was level access to the surgery and a wheelchair available in the waiting room to assist patients with poor mobility. Arrangements were in place to see patients in ground floor consultation rooms if they were unable to access the first floor. The practice offered home visits to patients due to mobility or medical issues.

The practice had been instrumental in setting up two voluntary organisations, to which they now referred patients. Riverside befrienders offered transport to appointments and prescription collection. Bovey Community Care assisted in a hospital discharge support and have supported patients after their discharge from local hospitals. This support included befriending and social support with tasks such as shopping, carer relief, dementia support and trips out of the house.

People with long term conditions

Good

The practice maintained a register of all patients with long term conditions and had computer prompts to remind staff to book additional screening as required.

Summary of findings

The practice had a lead GP and nurse for each clinical area and developed clinical protocols to ensure best practice was followed.

Patients with long term conditions were invited to attend the practice for an annual check. Patients were offered vaccination against flu, shingles, and pneumonia at this appointment. Receptionists had also been trained to identify these patients opportunistically and arrange appointments to meet all their needs in one visit.

The practices offered weekly nurse led clinics for diabetes, cardiovascular disease and hypertension and these clinics were overseen by a specific GP.

The practice referred housebound patients to the community nursing team for follow up of their long term condition.

There were systems in place to identify patients who were carers. The carers were offered health checks.

A GP met with the community nurse to review palliative care patients every four weeks.

GPs contacted patients following bereavement of their relatives to offer support and ensure emotional needs were met.

Patients with long term conditions were able to access support from the Riverside befrienders and Bovey Community Care.

Families, children and young people

Good

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse. Safeguarding was a standing item on the monthly clinical meeting agenda. All staff knew who the Safeguarding Lead was in the practice. At risk families, children and young people were flagged on the computer system and families were encouraged to register with the same GP.

Receptionists had been given authority to book children in for a face-to-face appointment with a GP without the need for triage for urgent appointments.

The Health Visitors were accommodated in the surgery and had appropriate access to the medical records and direct access to the GPs throughout the day for urgent matters. Ante-natal care was provided by a team of midwives who worked with the practice. A midwife held clinics at the practice, had appropriate access to the patient's computerised notes and could speak with a GP should the need arise.

Summary of findings

The practice offered childhood immunisations and contacted patients and liaised with the health visitor regarding non-attenders. The practice offered walk-in flu vaccination clinics dedicated for children.

Patients had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. There were also designated gynaecological appointments available twice a week.

The waiting room had a defined children's play area.

Working age people (including those recently retired and students)

Good

Routine appointments were bookable up to four weeks in advance and extended opening was available on Monday evening and Saturday mornings at either one of the two practices. The practice offered telephone consultations to any telephone number provided by the patient.

Patients could book appointments and request repeat prescriptions through the website. Prescription requests could be transferred electronically to a pharmacy of the patient's choice. Adequate supplies of medication were provided for holiday/business trips. Text reminders for appointments were sent to patients.

NHS health checks were offered to patients over 40 years of age. Advice regarding diet, healthy lifestyle and smoking cessation were also available during some of the extended hours, for example on a Saturday morning.

Patients had access to a patient newsletter and could receive this via email.

Flu vaccination clinics were arranged on two Saturdays and patients could choose which practice to attend.

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

People whose circumstances may make them vulnerable

Good

All patients were registered with a named GP to encourage continuity of care. If appropriate the computer system was flagged with concerns regarding vulnerable patients. The practice maintains a register of its top 2% of at risk patients which may include vulnerable patients with a care plans. These patients were reviewed every three months. Concerns about vulnerable patients were discussed at monthly clinical meetings.

Summary of findings

The practice worked closely with the district nurses and health visitors who were based in either of the practice premises. These health care professionals had access to the patient medical records. The practice had access to a rapid response service for vulnerable patients to prevent hospital admission.

The practice worked with two voluntary organisations who provided transport to appointments, prescription collection. GPs could also refer patients who needed help with shopping, reading, help around the house, and companionship. More recently the service has extended to support patients on discharge home from hospital.

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

Systems were in place for the practice to alert the out of hours service of vulnerable patients with a special message.

People experiencing poor mental health (including people with dementia)

Good

The practice had a lead GP for mental health and dementia and maintained a patient register for these areas. This register was used to organise and offer annual mental health reviews to patients with long term mental illness and dementia.

Patients who were attending an appointment for a review of their chronic disease were screened and asked about underlying depression.

Patients were encouraged to book double appointments if they wanted longer to discuss mental health issues.

The practice had access to a local Crisis Team and Depression and Anxiety Service.

The duty GP system ensured access at any time of day for patients with acute mental health need. The GPs were able to prescribe medicines for acute mental health problems if appropriate.

Summary of findings

What people who use the service say

We spoke with 15 patients during our inspection. We also received 5 emails from members of the virtual patient participation group who explained their views as a patient.

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 17 comment cards. Comment cards were detailed. There were no negative comments. Positive comments indicated that patients appreciated the caring staff, excellent care and appointment system. Patients made reference to the good care they received, the dignity and respect they were shown and praised the staff who listened and provided thorough treatment and care.

These findings were reflected during our conversations with the 15 patients we spoke with, the 5 patients who emailed and from looking at the practice's 11 friends and family test results from December 2014 to March 2015 and from the national practice patient survey from November 2014.

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

Of the 11 friends and family test results eight patients said they were extremely likely, or likely to, recommend the practice. There were many positive comments to support our findings.

Patients were happy with the appointment system and said they could either book routine appointments two weeks in advance or could make an appointment on the day.

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 commented on the building always being clean and well maintained. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

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

Areas for improvement

Action the service SHOULD take to improve

- Ensure patients are aware of the chaperone service.
- Ensure staff have access to appropriate training in the Mental Capacity Act 2005

Outstanding practice

The practice is outstanding in providing effective care. This can be demonstrated by the development of community working to enhance patient well being.

- The GPs at the practice had been instrumental in supporting and setting up two community groups of volunteers called Bovey Community Care and Riverside befrienders. One of the GPs remains as a

Summary of findings

Trustee and supports where required. The practice works closely with both organisations which are now self-sufficient. The practice take the bookings for transport with Riverside Befrienders and offer general help and support when it is needed for administration, advertising recruiting etc. Last year the befrienders carried out 967 journeys with patients. The Bovey Community Care group started offering support in June 2013, have over 40 volunteers, and received over 100 referrals for social support. The GPs at the practice facilitated the group to introduce hospital discharge support in November 2014 and attend hospital discharge meetings with representatives from the group. The group have supported eight patients after their discharge from local hospitals. At present the group were actively supporting 28 clients in the community, with befriending, help with shopping and prescription collection, dog walking, carer relief, dementia support, trips out of the house, specific support for the visually impaired, signposting, support to engage with local social groups, help with applying for benefits, and the preparation of nutritious meals. For example, One patient with dementia was supported by a volunteer who takes the patient out for long walks, and spends time engaging in which were once the patient's hobbies. The examples we were given showed a positive impact on the patients well-being and demonstrated support and respite for the carers.

The practice had well organised processes in place and the administration and management of the practice was outstanding in that documentation, policies and procedures were of a very high standard. For example, personnel files from 20 years ago contained everything that would be expected with changes of legislation in recent years and were well organised and structured. Practice policies were comprehensive and complete and had been produced by the practice rather than being copied from templates or other practices.

Bovey Tracey and Chudleigh Practice

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 Bovey Tracey and Chudleigh Practice

Bovey Tracey and Chudleigh Practice was inspected on Wednesday 15 April 2015. This was a comprehensive inspection.

Riverside Surgery is situated in the town of Bovey Tracey on the edge of Dartmoor national park. Riverside surgery is the main practice of two practices, the other being Tower House Surgery, who come under the Bovey Tracey and Chudleigh practice. Together, the practices provide a primary medical service to approximately 14,400. Riverside Practice provides primary medical services to 9,578 patients of a diverse age group. The practice have one patient list and staff work across both sites, although the GPs tend to spend the majority of time at one practice to provide continuity of care for patients. The practice is a training practice for doctors who are training to become GPs.

There is a team of eight GP partners and two salaried GPs within the organisation. Partners hold managerial and financial responsibility for running the business. There are five male and five female GPs. The GPs were supported by a practice manager, finance and governance manager, a nurse practitioner, four practice nurses, and five health care assistants. The clinical team were supported by additional reception, secretarial and administration staff.

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

The practice is open from Monday to Friday, between the hours of 8.30am and 6.00pm. Appointments can be booked up to four weeks in advance and take place between 8.30 and 17.30. The practice offered extended appointments on alternate Monday evenings at Riverside Surgery from 6.30pm - 9.00pm and on alternate Saturday mornings at Tower House Surgery from 8.30am - 11.00am. Patients from Riverside and Tower House can book into either clinic.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before conducting our announced inspection of Bovey Tracey and Chudleigh practice, 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 Torbay and South 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 15 April 2015. We spoke with 15 patients, a member of the patient participation group, five GPs, five of the nursing team and seven members of the management, reception and administration team. We also received 5 emails from members of the virtual patient participation group who explained their views as a patient. We collected 17 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 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. Staff explained they would report the issue and would complete a document which was then managed by the GPs and practice manager for action. This was then reviewed at the monthly clinical governance meetings. There was a culture of learning from incidents. Staff said the process was open and supportive and used as a way of improving the service. For example nursing staff explained how a complaint from a patient had highlighted a risk regarding ear syringing. Staff had reviewed and changed the policy to ensure patients were given more information about the risks associated with the procedure.

Learning and improvement from safety incidents

The practice had an efficient system in place for reporting, recording and monitoring significant events, incidents and accidents. We asked to see safety records, incident reports and minutes of meetings where these were discussed. These detailed documents showed how the practice had actioned these and learnt from them. The practice manager kept a summary of such events to monitor trends.

Significant events were a standing item at the monthly clinical meetings. Staff were able to give examples where the practice had learned from these and findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff were able to give examples of the action taken as a result of significant event. For example, an event relating to incorrect labelling of a blood sample had resulted in all staff being reminded to use the correct process for labelling samples. Other examples included actions and learning following a medicines error.

The practice did not just use safety incidents where things had gone wrong. For example, an emergency situation had been managed by staff. Following this the team got together to debrief and recognise where systems had gone well, and where they could be further improved.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The majority of staff said this would include discussing and reporting to their line manager. Contact details were easily accessible using the policies on the computer intranet. The practice manager was in the process of introducing quick reference flow charts in clinical areas.

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or information about vulnerable patients.

There was a chaperone policy, although patients were not all aware this was available. (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). Nursing staff, including health care assistants acted as chaperones when required.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy of monitoring fridge temperatures and maintained records to show this process was followed each day.

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

Clinical Commissioning Group (CCG) data showed that the practice was a high performer with regard to prescribing. Practice staff used CCG guidance and the CCG formulary to ensure they were prescribing within acceptable ranges. One of the GPs was nominated the lead for prescribing. The practice used computerised tools to prompt GPs when prescribing medicines to ensure the medicines were the most appropriate and cost effective medicine to use.

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

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

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Nursing staff had received training about infection control specific to their role and received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The last infection control audit had been performed in June 2014. This audit had resulted in the introduction of wall mounted soap dispensers and clinical cleansing wipes for equipment.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice had last carried out a check in October 2013 and were due a review in October 2015. Water testing for legionella took place every six months and hot water temperature checks were performed weekly by staff.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Nursing staff told us that all clinical equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Records showed that portable electrical equipment was routinely tested and had last been completed in January 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Recruitment records we looked at were

Good

Are services safe?

well organised and contained evidence of all recruitment checks that had been undertaken prior to employment. Some files dating back 20 years contained evidence of detailed checks expected in recent changes in legislation. We looked at four staff files. All of which contained references. There were interview records seen to show that the procedure was consistent and met equal opportunities. All files contained proof of identification, qualifications, and registration with the appropriate professional body. Further systems were in place to ensure these annual checks were kept under review. All files for nurses and GPs contained evidence of and criminal records checks through the Disclosure and Barring Service (DBS).

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had written a health and safety policy in place. Health and safety information was displayed for staff to see.

Risk assessments and health and safety audits had been performed. Staff said that any risks within the building would be discussed at GP partners' meetings and within team meetings.

There were issues raised during the inspection about potential risks in security of the building. These included some unused rooms being unlocked and access to the building. These were reported to the management team who circulated the security policy to all staff and reviewed the building risk assessment to ensure unnecessary risks were present. Staff explained that valuables were always locked away.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available and included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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

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

The practice had carried out a fire risk assessment which was booked for review. Fire alarms were tested weekly. Annual fire drills including a full evacuation were done last November including a missing person test. As a result of this test staff were reminded of the procedure and a change to procedure resulted from this.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines were disseminated at the monthly clinical meetings and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Staff explained they used these guidelines to influence the care templates they used at the practice.

The nursing team held specialist diabetes, cardiovascular and high blood pressure clinics at the same time with a named GP who oversaw and was available for support during these sessions. Nurses explained that this allowed them to manage the routine specialist conditions such as diabetes, heart disease and asthma and enabled the GPs to see the patients with more complex needs. The GPs were complimentary about the skills and knowledge of the practice nurses. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

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

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The systems used were efficient and used by all staff to capture the most information and used to prompt additional checks. For example, one administrator kept a spread sheet to prompt GPs and nursing staff to keep patient care plans under review. Staff said this system worked well.

The practice showed us a summary of 12 clinical audits that had been undertaken in the last two years. All of these had been completed and had been discussed by the GPs. Three were completed audits where the practice was able to demonstrate the service they provided was appropriate. For example, referral rates were appropriate. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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

prescribed these medicines and altered their prescribing practice, in line with the guidelines. Staff also discussed the audit findings at the monthly clinical meetings to ensure prescribing practices were appropriate.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, data showed that 81.23% of patients on the diabetic register had a good blood sugar level compared to the national average of 77.75%. The practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as individuals, teams and as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around education, support, audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, the practice were using a computer system to prompt the nurse practitioner and GPs to ensure the medicines being prescribed were in line with local guidance. There were systems in place to ensure that patients receiving repeat prescriptions had been reviewed by the GP. There were also systems, checks and computer data which prompted routine health checks were being completed for long-term conditions such as diabetes, asthma and heart disease. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Blank prescription pads and printer forms were held securely on arrival in the practice, before use. Records were held of forms received. No pre printed prescription pads were left in the consulting or treatment rooms. Systems had just been introduced to record when blank forms were taken for use, to enable an audit trail to be maintained of the whereabouts of these forms.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with performing mandatory training such as safeguarding and infection control. All staff had received annual basic life support. We noted a good skill mix among the GPs with professional interests in women's health, minor surgery, diabetes, palliative care, training and education being covered. A number of GPs had an interest and extensive experience in gynaecology and as a result performed a gynaecology clinic with a member of the nursing team. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and travel health. Those with extended roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice was a training practice. There were no GP trainees on duty on the day of the inspection. The practice had last been inspected by NHS Health Education department in September 2014 and had been reapproved as a training practice.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge

summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had systems in place to ensure that the passing on, reading and acting on any issues arising from communications with other care providers on the day they were received took place. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held clinical meetings each month which was attended by the multi-disciplinary team. The agenda items included the review of unplanned admissions register, review of palliative care patients, review of patients with a new cancer diagnosis, review of deceased patient register, review of safeguarding issues and vulnerable patients. The meetings were also a time for staff to discuss and significant events and NICE updates. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We spoke with a health visitor who was at the practice on the day of our inspection. They also said the meetings were invaluable.

One of the GPs at the practice had been instrumental in supporting and setting up two community groups of volunteers called Bovey Community Care and Riverside befrienders. The GP remains as a Trustee and supports where required. The practice work closely with both organisations which are now self-sufficient.

The practice take the bookings for transport with Riverside Befrienders and offer general help and support when it is needed for administration, advertising recruiting etc. In the last year the Riverside befrienders have transported 1016 patients and carers.

The Bovey Community Care group started offering support in June 2013, have over 40 volunteers, and received over 100 referrals. The GPs at the practice facilitated the group to introduce hospital discharge support in November 2014 and attend hospital discharge meetings with representatives from the group. The group have supported eight patients after their discharge from local hospitals. At present the group were actively supporting 28 clients in the community, with befriending, help with shopping and prescription collection, dog walking, carer relief, dementia support, trips out of the house, specific support for the visually impaired, signposting, support to engage with local social groups, help with applying for benefits, and the preparation of nutritious meals. For example, one patient with dementia had been supported by a volunteer who took the patient out for long walks, and had spent time engaging in which were once the patient's hobbies. The examples we were given showed a positive impact on the patients well-being and gave support and respite for the carers.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, managing recalls for cervical screening. The practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and some, but not all staff had received training for this. The staff were aware of the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had worked with other healthcare professionals, for example

with patients with learning disabilities. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually. For example 80.6% of the patients with learning disabilities had attended for a health care review. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

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

Health promotion and prevention

New patients were offered a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice consistently performed well in the locality when providing screening services. For example, Riverside Surgery scored 9th out of 48 local surgeries for Retinal Screening for Diabetic Patients 84.4% and had scored 79.91% for breast screening compared with the national average of 72.35% and the local average of 72.3%.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 1681 patients in this age group had taken up the offer this year of the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of

93% of patients over the age of 16 with a combination of conditions including Stroke, high blood pressure, asthma, mental illness and chronic pulmonary disease. The practice had actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success. For example, patients who had attended the Smoking Cessation Clinic in the last 12 months and have successfully quit was recorded as 56%.

The practice's performance for cervical smear uptake was good. For example, the percentage of women (aged from 25 to 64) whose notes record that a cervical screening test has been performed in the last five years was 87% which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG. For example, 80.5% of the 2450 patients who were over 65 years of age had received the flu immunisation. The practice was placed 13th out of 35 practices in the CCG for performance. In addition, 63% of the 728 eligible patients between the ages of six months and 65 years had received their immunisation for flu. This meant the practice had been 7th out of the 35 practices. The practice also performed well for childhood vaccines. Data showed that 90% of children had received their childhood vaccines and boosters.

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 November 2014 and results from the friends and family test performed between December 2014 and March 2015. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice scored comparably to national scores on the GPs treating patients with care and concern. For example 83% of 405 respondents said they were treated with respect compared to the national average of 84%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There were no negative comments. We also spoke with 15 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

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

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients feedback about the practitioners fell in the top 25% of results in the country. Survey data showed that patients thought 77% of respondents were given enough consideration.

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 17 comment cards we received was also positive and aligned with these views.

We were shown a system which monitored care plans for vulnerable patients and made sure these were kept under review. This system ensured GPs were able to discuss the care needs and patients wishes with the patients and their carer.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, patients we spoke with on the day of our inspection and the comment cards we received showed that patients had received help to access support services to help them manage their treatment and care when it had been needed.

Notices and leaflets in the patient waiting room, information on the TV screen and the patient website told patients how to access a number of support groups and

Good

Are services caring?

organisations. There were systems in place to identify patients who were carers. The carers were offered health checks and 70.80% had received a check in the last five years. 39.7% of carers had received their seasonal flu vaccine. The practice were 14th out of 35 CCG Practices for this.

Staff told us that if families had suffered bereavement, the member of staff who takes the message then informs the staff and contacts the GP who then coordinates any follow up. Further care is usually organised through the Bovey community group of volunteers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, following poor feedback on a survey regarding appointment access the practice consulted the PPG and performed a detailed survey and made changes to the appointment system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, local nursing homes and care homes. As a result the GPs all visited the local four care homes to ensure patients are still able to see the GP of their choice.

The premises were purpose built. There was no passenger lift to assist patients reach the first floor rooms although the majority of consultations were offered on the ground floor. There was a path externally which led to the first floor. Waiting rooms were of a good size and enabled patients to negotiate in wheelchairs or pushchairs. Treatment rooms and consultation rooms were of a good size.

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

Access to the service

The practice was open from Monday to Friday, between the hours of 8.30am and 6.00pm but closed between 1pm and 2pm. The practice had made a decision to have protected time for teams to meet for lunch as well as staff meetings and training. Appointments could be booked up to four weeks in advance and took place between 8.30 and 1pm and 2pm until 5.30pm. The practice offered extended appointments on alternate Monday evenings at Riverside Surgery from 6.30pm - 9.00pm and on alternate Saturday mornings at Tower House Surgery from 8.30am - 11.00am. Patients from Riverside and Tower House could book into either clinic.

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

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

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

Patients had reported dissatisfaction with the appointment system in the November 2014 survey. As a result the practice had made changes. These included the introduction of a GP triage for patients whose clinical condition would not wait until the next available routine appointment. The practice also increased the clinical sessions by 3 per week and recruited additional nursing, admin and reception staff to improve access for patients. The patient feedback we received indicated patients were now satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to but often had to wait longer if they wanted to see a specific GP. They said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

Information was available in the patient handbook and on the website about how patients could make a complaint. Leaflets were displayed in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice kept complaints register for all written and verbal complaints, concerns and feedback. We looked at all 39 of these records received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way. The practice also used complaints as a way of improving the service.

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

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a mission statement as part of the practice's statement of purpose document. The mission statement read 'To provide the highest standards of health care for our patients in the local community within resources available to us; and to promote a healthy work/ life balance throughout the organisation.' The aims and objectives included a promise to work collaboratively with South Devon & Torbay Clinical Commissioning Group to improve the health of the local population; and to improve the speed and quality of care that patients receive; and to improve the quality of working lives for those in primary care. The aims and objectives also included an aim to work towards achieving the highest standards in the Quality and Outcomes Framework to improve the quality of patient care and to protect practice income.

We spoke staff and they all knew and understood the mission statement and aims and objectives and values and knew what their responsibilities were in relation to these. Staff said they thought the team morale was high and this reflected on the level of care that was provided.

Governance arrangements

The practice was well organised and had effective processes in place. The administration and management of the practice was outstanding in that documentation, policies and procedures were of a very high standard. For example, personnel files from 20 years ago contained everything that would be expected with changes of legislation in recent years and were well organised and structured. We saw that this robust process was followed for recently recruited staff. Practice policies were comprehensive and complete and had been produced by the practice rather than being copied from templates or other practices. All nursing, administration and the majority of GPs knew how to access the policies which were located on the practice intranet. The administration supported the GPs by ensuring any organisational policies were produced.

There was a clear management and clinical leadership structures in place with named members of staff in lead roles. For example, there was a GP who was the lead for safeguarding. There was a nurse lead for infection control. We spoke with members of the administration and nursing team who were clear about their own roles and responsibilities. They all told us they felt the practice was organised and ran efficiently. Staff told us they valued, well supported and knew who to go to in the practice with any concerns.

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

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

The practice held monthly clinical meetings. Staff explained there was a clear structure in place to make sure that performance, quality and risks had been discussed. Records of these meetings were detailed and kept to demonstrate and communicate any actions, learning points and discussions.

Leadership, openness and transparency

Staff explained that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings, clinical meetings or informally. All staff expressed a mutual respect of their colleagues. Staff said the management and the GPs were approachable and supportive.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey which showed that patients had not been satisfied with the appointment system. This had resulted in the introduction of a GP triage for patients whose clinical condition would not wait until the next available routine appointment. The practice also increased the clinical sessions by three per week and recruited additional nursing, admin and reception staff to improve access for patients.

The practice had a small virtual patient participation group (PPG), although one member is a member of the local PPG

Are services well-led?

Good

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

forum group. The PPG told us they had been contacted ad hoc to give feedback on issues. Other PPG members told us they had influenced and had assisted with the patient satisfaction survey. Other influences had included changes to a waiting area in the practice. Patients had been asked to wait to see nurse in the corridor. However, the PPG highlighted confidentiality issues. Action was taken immediately and patients now wait in the main waiting room.

Patients we spoke with were unaware of the PPG group and PPG members were unaware whether a GP was involved in the group. Suggestions were made by patients and PPG members to increase awareness of the group.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. We were given examples of where staff had come up with ideas to improve the service. These included how to arrange staff rotas for clinics.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training, peer support and mentoring. Nursing staff said that regular appraisals took place which included a personal development and training plan. Staff told us that the practice was very supportive of training and that they had never been refused training related to their role. For example, the lead nurse, who had worked with the practice for many years had been supported to train in chronic disease management, gain nurse practitioner and nurse prescriber status.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and clinical governance meetings to ensure the practice improved outcomes for patients. For example one significant event that was not caused by practice staff was used as a learning opportunity. Minutes of the clinical meeting showed that all staff, including GPs were reminded of correct procedures and measures put in place to prevent the situation arising again. Staff said there is never a blame culture used at the practice but each situation was used to improve the care and treatment and used as a reminder for all staff.