Newcombes Surgery

Quality Report

Newcombes
Crediton
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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?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Newcombes Surgery on 28 April 2015. This was a comprehensive inspection.

Overall the practice is rated as GOOD.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was good for providing services to older people, vulnerable people and people with mental health needs including dementia, people with long term conditions, families, children and young people and working age people.

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

- There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients. GPs and nurses closely monitored the health and wellbeing of older and vulnerable patients with a learning disability and/or complex mental health needs.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- 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.
- Risks to patients and staff were assessed and well managed. Health and safety was taken very seriously and staff managing it were trained and effective in performing this role.
- 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.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. Patients reported high levels of satisfaction and confirmed that routine and urgent appointments were available the same day and staff were flexible and found same day gaps for patients needing routine appointments.

Summary of findings

- 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. There was an active Patient Participation Group (PPG) at Newcombes Surgery, which was influencing the way the practice developed.
- Audits were used by the practice to identify where improvements were required. Action plans were put into place, followed through and audits repeated to ensure that improvements had been made.

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?

The practice is rated as good for providing safe services.

Good

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. 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. There were enough staff, and recruitment practices ensured that staff were fit to work at the practice or safe to carry out chaperone duties.

Are services effective?

The practice is rated as good for providing effective services.

Good

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's 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, which included strong links with other health and social care professionals supporting patients at the end of their lives.

Are services caring?

The practice is rated as good for providing caring services.

Good

Data showed patients rated the practice higher than others for some aspects of care. The CQC comments cards received and discussion with patients on the day all provided positive feedback. A common theme was that the staff were extremely person-centred and patients were always treated with respect and compassion.

Staff we spoke with were aware of the importance of providing patients with privacy and offered a room away from the reception area to discuss confidential matters. Information was available to help patients understand the care available to them.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

appointments available the same day. Flexible appointments were available and arranged with patients to meet their needs. This included appointments outside of normal opening hours by arrangement for working age patients. 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 with staff and other stakeholders was reviewed and acted upon.

Are services well-led?

Good

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

It had a clear vision and strategy, which focussed on providing a 'family doctor' service for multigenerational families living in the village and surrounding areas. 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. 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 practice had an active patient participation group (PPG), which was influencing the development of 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.

Older people

Good

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example patients over 75s with a risk of fracture prescribed a bone sparing agent

had increased to 83.3% in April 2015. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.

Patients with complex care needs were well monitored by the practice working in partnership with other agencies. They were responsive to the needs of older people, and offered GP home visits and rapid access appointments for those with enhanced needs. Information systems enabled the practice to appropriately share important clinical and social information about patients with complex needs. This facilitated continuity of care for those patients.

GPs were proactive in reducing risks associated with poly pharmacy for older people. For example, patients prescribed multiple different medicines had been frequently reviewed and changes made to reduce these.

Pneumococcal vaccination was provided at the practice for older people. Shingles vaccinations were also provided to patients who fitted the age criteria. Patients were contacted to offer them the opportunity to make an appointment to have the vaccination, which had increased the uptake of patients being given this.

The practice held regular carers clinics and worked with a community support worker to provide additional help for carers. The practice worked in collaboration with local day centres in the Crediton area which included a befriending service for people. Vulnerable patients were signposted to these services and this was done compassionately and patients in this position were treated with dignity.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

The practice nurses had a lead role in chronic disease management and closely monitored patients with diabetes, asthma and/or chronic respiratory disease. Patients at risk of hospital admission

were identified as a priority. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice held multidisciplinary meetings every month to review the needs of all patients with complex long term conditions.

Longer appointments and home visits were available when needed. Home visits for patients newly discharged from hospital were undertaken jointly with the community nursing team to carry out an assessment and arrange additional support where needed. All patients newly discharged from hospital were contacted within 48 hours.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be carried out at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. The practice had purchased equipment which allowed tests to be carried out onsite, providing patients with instant results and advice about changes to the dosage of medicines for example.

Health education around diet and lifestyle was promoted by the practice. The practice took an early intervention approach and helped identify and signpost patients to external support. This included signposting patients to the smoking cessation service at Crediton hospital.

Families, children and young people

Good

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

Children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances were identified and closely monitored. Immunisation rates were within normal ranges for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The waiting room had toys for children to play with whilst waiting for their appointments.

Summary of findings

Emergency processes were in place for acutely ill children, young people and pregnant women with acute complications. For example, ill children were seen quickly by GPs without having to wait.

The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance. For example, the health visitors had six weekly meetings with GPs and the advanced nurse practitioner and said they could access support from the team at any time.

Young people had access to information about sexual health matters and could request chlamydia screening and be seen by either a GP or practice nurse of their choice. Social media websites were being used to promote healthy living and obtain feedback from young people about their experience of care and treatment at the practice.

Support was being accessed for parents from childrens workers and parenting support groups where relevant. Parents with children confirmed that they were always present during consultations. Staff understood Gillick principles with regard to assessing whether a young person was able to understand and therefore consent to treatment. Parents told us that all of the staff engaged well with their children so that they found it a positive experience when attending the practice for appointments.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had online facilities which enabled patients to book appointments and repeat prescriptions on-line. The practice website offered information about the full range of health promotion and screening available for this group. Where needed appointments were offered to working patients outside of normal opening hours by arrangement either before or after the working day. Appointments were available for patients to see a GP, practice nurse or health assistant and these could be in person or by telephone. Patients would be able to request repeat prescriptions on-line within a month, at the local pharmacy or in person at the practice. Repeat prescriptions were being given with supplies for longer periods on a needs basis and in agreement with the patient's GP.

Overseas travel advice including up-to-date vaccinations and anti-malarial drugs was available from the practice nurse within the practice with additional input from the GP's as required.

Opportunistic health checks were being carried out with patients as they attended the practice. This included offering referrals for smoking cessation to Crediton hospital, providing health information, routine health checks including blood tests as appropriate, and reminders to have medication reviews.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. Information used was accessible and in different formats suitable for people with learning disabilities. Longer appointments were available for people with a learning disability and their carers were invited to join them reviews if they wished them to do so. The practice liaised with the learning disability nurse specialist who used techniques to help reduce the patient's anxiety before procedures were carried out.

Shared care arrangements were in place for patients with complex mental health needs. The practice worked closely with the community mental health team and regularly reviewed each patient. Every patient had a care plan and risk assessment, which was reviewed.

Health education, screening and immunisation programmes were offered as appropriate. This included alcohol and drug screening. Patients with alcohol addictions were referred to an alcohol service for support and treatment and to the local drug addiction service.

The practice worked closely with the community matron to arrange visits to vulnerable patients to assess and arrange any equipment or other assistance needed by the patient and their carers. Systems were in place to help safeguard vulnerable adults.

Although there were no temporary sites close by, the practice had an anti-discrimination policy whereby no barriers were put in place to a homeless person wishing to register with the practice. The practice had arrangements in place where the patient was encouraged to use the practice address for correspondence.

Carer checks were carried out and the practice hosted a carer support worker clinic every month to support patients. Carers were also signposted to local support such as a Memory café and other community initiatives in Crediton.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

The practice held a list of all patients experiencing poor mental health. Flexible services and appointments were available, which enabled patients experiencing poor mental health to have longer appointments up to an hour at quieter times of the day, avoiding times when people might find this stressful.

Patients experiencing mental health crisis were supported to access emergency care and treatment. The practice worked collaboratively with the community mental health team and consultant psychiatrists from the mental health partnership trust.

Appointments with patient were seen as an opportunity to screen and signpost them to additional services. In house mental health medication reviews were conducted to ensure patients received appropriate doses of medication. For example, patients taking lithium had regular blood tests to ensure safe prescribing.

Advice and support was sought as appropriate from the psychiatric team with referrals made for psychiatry review or entry into counselling. Patients could refer themselves or be referred directly to the depression and anxiety counselling service, which ran appointments at the practice.

Early identification of patients with suspected dementia were being screened and referred to the memory clinic for diagnostic tests. GPs worked closely with the NHS memory clinic, consultants and other mental health workers specialising in care of older people. Patients had care plans in place, which supported their on-going changing needs and those of their carers. The practice worked closely with a social centre at Crediton hospital and other local initiatives designed to support patients experiencing poor mental health.

Summary of findings

What people who use the service say

The practice sought feedback from patients in several ways. Three surveys, including the 2014 national GP survey showed that results for Newcombes Surgery was comparable with the clinical commissioning group (CCG) and national averages. Patient satisfaction was comparable with the national average, 86.84% compared with 85.76% in the 2014 GP survey. Overall 90.28% patients found it easier to get through to the practice compared with the national average of 75.4%.

The practice had provided patients with information about the Care Quality Commission prior to the

inspection. Our comment box was displayed and comment cards had been made available for patients to share their experiences with us. Fifty two patients gave feedback at the inspection, in person (23) or in writing (29). All confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Newcombes Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and another specialist advisor who was a practice manager and an expert by experience.

Background to Newcombes Surgery

The GP partnership run the practice from Newcombes Surgery and provide general medical services to people living in the town of Crediton the surrounding villages. The practice covers approximately 50 square miles. The practice has a 4x4 and bad weather policy, which is used during the winter months when roads in rural areas can become inaccessible to normal vehicles.

At the time of our inspection there were 6938 patients registered at the practice. There is a higher percentage of patients over 45 years when compared to national statistics. The practice is placed within the mid to lower range of the social deprivation scale. The practice supports people living in five adult social care homes in the area.

The practice is contracted to provide Personal Medical Services (PMS). Newcombes Surgery provides some enhanced services which include minor surgery, remote care monitoring, alcohol screening, extended hours access, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal, shingles and rotavirus immunisations as well as monitoring the health needs of people with learning disabilities.

There are five GPs at Newcombes Surgery; four are GP partners and one is a salaried GP (four female and one male). Newcombes Surgery is a training practice, with two GP partners approved to provide vocational training for medical students from Plymouth and Bristol medical schools. There was a GP registrar and F2 doctor on placement when we inspected the practice. When we inspected the GPs were supported by a female nurse practitioner who also held prescribing qualifications. There are three female practice nurses and one female health care assistant and a phlebotomist. There is a large administrative team managed by a practice manager.

Patients using the practice also have access to community staff including community nurses, health visitors, and midwives. NHS funded counselling is available on site at the practice, which patients are referred to by their GP or can self-refer to.

Newcombes Surgery is open from 8.30 am - 6pm Monday to Friday, with clinic sessions running from 9 am to 12.30pm and 1 pm to 5.30 pm. The practice has a sit and wait surgery every day from 11am where patients can turn up and wait for an appointment without having to prior book it. Home visits are carried out each day by appointment for vulnerable patients who are unable to attend the practice.

Flexible arrangements are offered for working age patients following consultation with patients and appointments are offered before and after clinics into the early evening by arrangement. Repeat prescriptions are prepared for patients and collected at a pharmacy chosen by the patient in Crediton.

During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Northern, Eastern and Western clinical commissioning group, which includes an arrangement for the Out of Hours service to take calls from 6pm.

Detailed findings

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

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 28 April 2015.

During our visit we spoke with 14 staff in total; three GP partners, a GP registrar, an F2 doctor, four practice nurses, a health care assistant, the practice manager and assistant manager, administrative and reception staff. We also spoke with 23 patients who used the practice. We observed how patients were being cared for and reviewed 29 comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Staff were readily able to locate this information and describe learning and changes made.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were discussed as they arose every week and the practice had made alterations to the GP rota to ensure all partners were on duty to be part of this. A formal review process was a standing item on the practice meeting agenda every three months.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Minutes of weekly meetings and quarterly practice meetings recorded learning and actions to be taken in relation to significant events and complaints. However, the practice did not then re-visit past event actions at these meetings as a safety net to ensure that learning was embedded across the team. Instead, the practice manager showed us a risk register onto which events in the process of being investigated had been recorded. Once completed the practice archived this information onto a shared drive. Interviews with staff demonstrated that learning from significant events was shared verbally with relevant staff and changes made. Staff knew how to raise an issue for consideration at the meetings and were encouraged to do so.

An example seen demonstrated learning from an emergency in which a patient had suffered a cardiac arrest in the town. Records showed that the team had worked well in an emergency situation and had successfully resuscitated the patient. Changes were made to the way the resuscitation equipment was arranged in grab bag to assist in locating this during an event. The practice also identified that in future resuscitation training would be provided in smaller groups so that there was greater benefit for staff attending.

National patient safety alerts were disseminated by email to practice staff and action taken to deal with these. We were shown copies of these on the practice intranet which was accessible to all staff.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. The practice had policies and procedures providing staff with guidance about identification of suspected abuse and the processes for reporting this. The policy for safeguarding children referred to 2011 national documents and had not been updated to include guidance from the document 'Working Together 2013 and Intercollegiate Guidelines 2014' and the Royal College of GPs Safeguarding Toolkit 2014. However, discussions with staff demonstrated that they were following these principles in practice.

Training records showed that all staff had received relevant role specific training on safeguarding. GPs, the practice nurses and administrative staff were able to describe 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 and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had a named GP partner as the lead 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. All staff we spoke with were aware who the lead was 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

Good

Are services safe?

child protection plans and linked with other siblings and family members registered at the practice. GPs were using the required codes appropriately on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. 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. For example, a GP partner shared an example where they had involved several agencies in safeguarding a patient with a long term condition that affected their ability to have insight into risks associated with their lifestyle. We met a Health Visitor who told us that the practice worked in close partnership with them and was responsive in protecting children and families at risk.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. 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. The practice nurses and two other named staff had been trained to be a chaperone. The practice had obtained a disclosure and barring check (DBS) for all the staff performing chaperone duties. We saw records showing that advice from the DBS had been obtained and risk assessments completed, which highlighted that this should be done in line with their role and responsibilities.

Medicines management

Medicines were stored securely in the treatment rooms and medicine refrigerators 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 nurses were responsible for monitoring these and knew the safe temperature range for storing medicines. Records for the previous month demonstrated that refrigerators were operating within the safe range described by staff.

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

Records of practice meetings demonstrated that actions had been taken in response to reviews of prescribing data. We reviewed data which showed that prescribing patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were average when compared with local and national data. There was a named GP partner who was the prescribing lead who worked closely with the medicines optimisation team to ensure that treatments prescribed for patients were safe, suitable and the most cost effective.

Nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Up-to-date copies of both sets of directions and evidence that practice nurses had received appropriate training to administer vaccines was seen. These included annual flu vaccination, including shingles vaccination and baby immunisations.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We specifically looked at how patients on anti-clotting medicines were monitored. There was a recall system in place, in which an appointment was made with the patient for the next monitoring check. Appropriate action was taken based on the regular blood results. A healthcare assistant was trained to use equipment, which provided the patient with immediate results. A computer system provided clear safety parameters, which alerted staff using these if results fell outside of the norm. GPs reviewed all results and signed off any changes to dose, which were immediately communicated to the patient.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw the practice system, which ensured that all unused prescription forms were stored securely and there was a signing in and out process.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) for patient use at practice during some procedures. Standard operating procedures set out how they were managed. These were being followed by the staff. Practice staff undertook regular audits of controlled drug prescribing to

Are services safe?

look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

The premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. In 29 comment cards, all of the patients remarked that they were satisfied with the standard of cleanliness at the practice. All 23 patients we spoke with were also satisfied with the cleanliness and infection control at the practice.

The practice had a named practice nurse and GP partner responsible for overseeing infection control measures, which were outlined in a policy and associated procedures. The practice nurse and lead GP partner had carried out audits for each of the last three years and improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and the actions implemented. For example, they had produced an annual statement of infection control measures. This summarised actions taken with the year and included a cleaning audit. We saw evidence that the practice had followed up matters with the cleaning company used because standards were not being adhered to. Cleaning staff had been issued with cleaning schedules, which highlighted the standards they were expected to achieve and a further audit was planned.

A practice nurse supported a lead GP partner in managing all infection control matters. The practice nurse showed us their training certificate, which demonstrated recent updates completed about infection control matters. She told us that links with the local practice nurse forum were crucial for being made aware of changes and updates also. We looked at the most recent audit and improvements identified for action had been completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and the actions implemented. For example, a trial of disposal privacy curtains had been started. We saw these in place in all of the consultation/treatment rooms and all curtains were labelled so that staff knew when to replace them within the six month period.

Staff showed us the practice intranet, which had all the policies and procedures on it. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff described how they would use these to comply with the practice's infection control policy. For example, we saw there was a designated box for patients to put samples in and a protocol followed each time it was emptied. The practice nurse handled the samples, carried out checks and then safely disposed of the contents. The practice had a needle stick injury policy in place and staff knew the procedure to follow in the event of an injury. We saw the practice used needles with an integral safety sheath, which was in line with current practice.

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 infection control protocol made reference to other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessment. Recent changes had been put in place when staff attended an update with regard to the disposal of hazardous waste. Additional receptacles with a purple lid were being used for the disposal of cytotoxic waste. Records showed that the practice was following suitable procedures for the management, testing and investigation of legionella. This is a bacterium that can grow in contaminated water and can be potentially fatal. The practice was carrying out regular checks in line with national guidance to reduce the risk of infection to staff and patients.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records demonstrated this was happening. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and certain types of equipment were calibrated for accuracy for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The practice had clear oversight of all the equipment being used so that it was fit for purpose and safe to use with patients. For example, all high risk equipment, such as mercury thermometers had been replaced with digital versions.

Staffing and recruitment

Information provided by the practice showed that staff retention at Newcombes Surgery was high with changes to

the team being made as staff retired. All of the staff told us they enjoyed working at the practice. We looked at five files for staff recruited since April 2013. Appropriate checks had been undertaken in line with role risk assessments. For example, all five files contained a criminal record check using the Disclosure and Barring Service (DBS). The practice had standard operating procedures covering recruitment, which included checks to be undertaken for temporary staff such as medical students and locum GPs. References had to be obtained from previous employers and immunisation, professional registration and indemnity insurance information checked at the point of employment. Records demonstrated that professional registration checks for nurses were carried out annually and revalidation dates for GPs were known and being monitored.

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 all members of staff to cover each other's annual leave and periods of sickness.

Staff told us there were enough staff to maintain the smooth running of the practice and to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. All 52 patients we received feedback from, either in writing or in person, confirmed that they were satisfied with the staffing arrangements at Newcombes Surgery.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see. A GP partner and assistant practice manager were the identified health and safety representatives. Records seen showed that appropriate checks were carried out, for example fire safety equipment had been tested in the last 12 months. Staff training records demonstrated that all staff had completed fire training, including a drill. The staff handbook showed that any new staff would receive an induction covering health and safety matters. Medical staff on training placements told us that the health and safety induction they were given when they started at the practice was thorough.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. In feedback cards, three patients specifically described their experience of being treated when their health deteriorated. These patients commented that they were seen immediately, treated quickly and were reassured by the staff attending them. For example, a patient had attended complaining of shortness of breath. They were seen quickly and diagnosed with a heart condition and were referred immediately for further tests at the hospital.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records demonstrated that all staff had received training in basic life support in the last 12 months. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

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, suspected meningitis, hypoglycaemia, severe asthma, overdose, nausea and vomiting and epileptic fit. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of the medicines we checked were in date and fit for use. The practice nurse carried out these checks and was proactively managing when these medicines were nearing expiry.

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. The practice had a corresponding severe weather policy and procedure as this could affect GPs seeing patients at home. A four wheel drive vehicle had been purchased for GPs to use and the vulnerable patients list identified if there were

any access issues getting to them in the event of severe weather. GPs had remote access to the IT records systems so were able to work from home in the event of severe weather.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. All of the staff listed on the training matrix had completed fire training and a fire drill had taken place in the previous 12 months.

Are services effective?

(for example, treatment is effective)

Good

Our findings

Effective needs assessment

GPs and nursing staff were able to give clear rationale for their approaches to treatment. They were familiar with current practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Weekly meetings were held at which the latest guidelines and research was discussed. Our discussions with the GPs and nurses demonstrated that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the latest NICE guidance about the management of patients with hypertension.

The GPs told us they lead in specialist clinical areas such as end of life care, chronic respiratory disease, family planning. The practice nurses had additional qualifications which allowed them to focus on specific conditions to help promote better patient health. For example, these included the diploma in asthma and chronic respiratory disease. GPs and nurses had developed templates for every condition patients might present with. Amendments seen demonstrated they continually updated these in line with NICE guidelines and any learning gained from training completed. For example, the nursing team had carried out a research search into preventative asthma care and treatment. As well as a risk management plan being produced, which was then individualised for each patient, the team had developed a template which was used for every patient consultation. For patients this allowed the clinical team to be more consistent in their assessments, advice and proposals for treatment. Safeguards were in place within the template, which required the nurse or GP to complete each field before being able to close it at the end of a consultation.

Prior to the inspection, we identified some variances in the data for specific areas of monitoring of patients with long term conditions for the year 2013/14. We looked at the quality outcomes framework (QOF) data for 2014/15 and saw that the overall performance had significantly improved in all areas from 70.2% in April 2014 to 97.2% by April 2015. Staff told us that the practice had identified the key areas that required improvement and had implemented a system whereby each nurse took the lead with a GP for monitoring the outcomes for patients. This lead to all areas being improved. For example, the percentage of patients with schizophrenia who had a care plan and alcohol risk reviewed had increased from 36.6% in 2014 to 96% by April 2015.

Data from the local CCG of the practice's all were receiving appropriate treatment and regular review. performance for antibiotic prescribing demonstrated that this was comparable to similar practices (22% versus national rate of 28%). The practice had also completed a review of case notes for patients with high blood pressure which showed The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients every week and had on site meetings with other health and social care professionals supporting them.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data showed that the practice was performing well in preventing unplanned admissions for vulnerable patients (12% compared with national average of 13.6%). Data seen also showed that patients with suspected cancers were referred and seen within two weeks.

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. GPs told us the practice values were based on continuity of care for patients, whom they knew extremely well. The practice was appropriately involving an independent mental capacity advisor (IMCA) to ensure that assessments were in the best interests of patients, particularly those with communication difficulties.

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 reviews, and managing child protection alerts and medicines management. The information was then collated by the practice manager to support the GPs to carry out clinical audits.

GPs showed us two clinical audits that had been undertaken in the last two years. Following each clinical audit, changes to treatment or care were made where

Are services effective?

(for example, treatment is effective)

needed and the audit repeated to ensure outcomes for patients had improved. For example we looked at a completed clinical audits of contraceptive coils fitted for women between 2013 and 2014. The main findings demonstrated that the complication rate remain comparable to the stated rates, attendance for the post fitting check had improved again and it was identified that patients who had this carried out in hospital were less likely to attend for a post fit check. The documentation showed that consent for the procedure had been recorded in 100% of patient notes.

Minor surgery audits also showed 100% compliance with obtaining consent and recording this in patient records over three years of audit between 2012 and 2014. Rates of complications from procedures such as wound infections were also audited and examined. Audits seen also confirmed 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.

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. For example, a review of all patients being treated with inhaler medicines for asthma had taken place. Agreed triggers for calling a patient in for a review had been put in place and named nurses responsible for carrying these out. Practice nurses were using evidence based practice and had produced an individualised assessment and plan for each patient which was colour coded. The plan for a patient highlighted certain known triggers, which would precipitate an asthma attack for that person with an escalating response plan including information about when to involve emergency services.

There was a protocol for repeat prescribing which was in line with current national guidance. Repeat prescription requests were reviewed daily and signed off by a GP. They also checked that 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.

The practice had implemented the gold standards framework for end of life care. GPs told us that a high percentage of patients using the hospital needed palliative care support. The nearest hospices to the practice were a considerable distance away in Exeter and North Devon, so GPs worked closely with the palliative care team to support patients to be at home and receive services there. A palliative care register was held and reviewed regularly with the palliative care team. This included weekly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term medical conditions were offered a minimum of yearly health reviews. The practice had set up a new system in response to learning from the previous years outcomes for patients, this had proved that the recall process for these reviews with dedicated staff time had been successful and improved the monitoring of patients.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Newcombes Surgery is a training practice providing placements for GPs and trainee doctors. Two GPs were approved trainers for this educational programme. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as teaching/training. GPs also had specific interests in developing their skills and disseminating this to the team. All of the GPs we spoke with confirmed they were up to date with their yearly continuing professional development requirements and all had revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

All nursing and medical staff undertook annual appraisals with a GP partner and the practice manager. The administrative team were appraised by the practice manager and assistant practice manager. The appraisal process included identification of individual learning needs. Mandatory training was provided

on-line and some staff showed us their training records and paper portfolios with certificates of completed courses. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For

Good

Are services effective?

(for example, treatment is effective)

example, one member of staff told us they had completed a hospital based phlebotomy course, given a mentor at the practice and assessed as competent to take blood from patients before working on their own.

The practice nurses received their clinical appraisal from a GP at the practice. The practice nurses told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. The nurses had received extensive training for her role, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines and undertaking cervical smears.

Working with colleagues and other services

GPs worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. There were policies in place outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. All GPs were responsible for seeing these documents and results and for taking action required. Staff understood their roles and felt the system in place worked well and our observations supported this. Results and discharge summaries were followed up appropriately and in a timely way. The task system within patient records worked well to assist the team in achieving this.

The practice worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children every 6 weeks. We met a health visitor who told us that the practice staff were responsive and took appropriate action if they had any concerns about a family or young child. Every three weeks there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team. The practice had a list of vulnerable adults and worked closely with community professionals. In two feedback cards, patients identified themselves as having learning disabilities and commented that they felt well supported and that their needs were met.

The practice facilitated other services such as the learning disability service and child and adolescent mental health service (CAMHS) being able to provide appointments closer to where patients lived by providing accommodation for them.

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. Special notes were shared with the 111 and Out of Hours services for patients with complex needs who needed continuity of care and treatment overnight.

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. Each member of staff had a log in password, which could only be accessed by them. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in promoting patient rights. A visiting learning disability health care specialist told us that the practice staff referred appropriate issues to them and involved an IMCA where necessary to advocate the patient's rights when an important decision about treatment was required. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. For example, the staff showed us accessible information used to gain consent and document a patient's health check. Nursing staff told us that the GPs and themselves worked closely with the learning disability nurse specialist.

Good

Are services effective?

(for example, treatment is effective)

All 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.

Procedures were in place for documentation of consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw an audit of these which showed that consent had been recorded in 100% of patient records reviewed. Practice nurses showed us anonymised examples of where patient consent had been recorded for procedures such as wound dressing, blood taking and cervical screening.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. This was young person friendly and in easy read formats. The practice website contained information and advice about other services which could support them. The practice offered new patients a health check with a nurse or with a GP if a patient was on specific medicines when they joined the practice.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be taken at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by patients we spoke with who were in this position as it avoided them having to travel to the ophthalmology clinic based at the main hospital in Exeter approximately 20 miles away.

There was information on how patients could access external services for sexual health advice. The practice provided confidential chlamydia screening and emergency contraception on request.

Child immunisation rates at the practice were comparable with national rates.

The annual flu vaccination programme had come to an end when we inspected and the team was gearing up for the next winter 2015/16. For patients within the relevant age range a vaccination against shingles was also available and information about this highlighted in the practice and website. Fifty two patients gave verbal and written feedback, some of whom had been eligible for flu vaccination. All of those patients in this positive verified that they had been able to access flu vaccination easily throughout the winter months. Patients had been contacted via text, phone or email and information about the programme was on the practice website.

Data showed that the practice performance with regard to offering smoking cessation had improved over the course of two years. By 2014-2015 96% of patients notes who were current smokers with physical and/or mental health conditions contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%. The smoking cessation service had moved to Crediton hospital where patients were referred to if they wished to have further help.

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding five years was 81.9 % which was comparable with the national average of 81.89%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received 29 completed cards and all were positive about the care and treatment experienced. Patients we spoke with (23) said they felt the practice offered exceptional services and staff were caring, helpful and professional. They said staff treated them with dignity and respect. Patients were complimentary about reception staff and told us that every effort was made to give them a same day appointment even for routine issues. Our observations of reception staff responding in person with patients or over the telephone also confirmed this.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations and we did not overhear any conversations taking place in these rooms.

We sat in the waiting room and observed patient experiences as they arrived for appointments. Reception staff were friendly and knowledgeable about patients and treated them with respect. GPs were kind and caring when we saw them accompanying patients from the waiting room to the consultation rooms.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were able to explain how they diffused situations to avoid further escalation of a patients frustration or anger. The locality had a violent patient scheme to which the practice could refer patients.

Care planning and involvement in decisions about care and treatment

Data showed that the practice was performing better with regard to maintaining a palliative care register for patients. GPs told us that treatment escalation plans were routinely discussed with patients on the register and their wishes about end of life care needs recorded. Minutes of multidisciplinary meeting demonstrated these were being followed for patients.

Patient survey information demonstrated that the practice achieved average levels of satisfaction and involvement in planning and making decisions about their care and treatment. For example, national survey data showed overall patient satisfaction was at 86.84% , which was comparable with the national average of 85.76%. Fifty two patients took part in this inspection all made very positive comments about their experiences of involvement in decisions about their care and treatment.

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being good at listening to their needs and acting on their wishes. Patients said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 29 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. Notices in the reception areas and information on the practice website explained the translation services available in a number of languages. Practice staff told us they recorded this information in the patient record. Staff told us there were patients who spoke Polish and Russian but were usually accompanied by relatives who spoke English. For those who did not have relatives, staff used the translation services and had access to a British sign language interpreter for deaf patients.

Patient/carer support to cope emotionally with care and treatment

The 29 comment cards we received were consistent in describing positive experiences about the care and treatment they had received. Patients highlighted that staff responded compassionately when they needed help and described as going beyond what was expected of them. The practice ran a monthly carers clinic in conjunction a community support worker, to provide practical and emotional support for patients who were carers. The practice signposted patients to the day centre in Crediton and services being run at the local community hospital.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice was in the early stages of using social media websites to provide support information and gain patient feedback. The practice's

Good

Are services caring?

computer system alerted GPs if a patient was also a carer. Written information was also displayed in the waiting room explaining the various avenues of support available to carers.

In 29 comment cards patients gave us several examples of the support received from practice staff when they had experienced difficult and challenging times in their lives. For example, an older patient was bereaved having lost their wife, was contacted by their GP and offered immediate support.

Counselling services were hosted at the practice and run by the mental health trust. For example, these included the depression and anxiety service to which patients could be referred or self-refer if they wished to. Information about this services was on display in the waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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 low turnover of staff and size of the practice meant that the team knew their patients very well and this was highlighted each time we spoke with a patient or in the 29 completed comment cards. The practice also held registers for each group including one for vulnerable patients so that the support, care and treatment was patient centred.

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.

Patients commented that the prescription system was good. The practice website provided information for patients about how they could request repeat prescriptions. This included online via the website, by fax or in person at the practice. We saw patients called in to collect their prescription at the practice. Other patients told us they opted to use a local chemist and found the system efficient.

The practice had arrangements in place for more vulnerable patients for example longer appointment times tailored to the patient's needs, which were typically up to one hour in length. Routine appointments were usually for 10 minutes and could be booked 4-6 weeks in advance.

The practice had participation group (PPG) and used different surveys and the 'Friends and Family Test' to obtain feedback. Services were being developed in conjunction with the needs of patients. For example, the practice saw that there were challenges in covering the wide rural area so were in the early stages of planning a merger with a neighbouring practice and were due to consult with patients about this.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services. Advocates were used were appropriate to promote patient's rights, particularly those with learning disabilities.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed or were completing the equality and diversity training. All of the staff told us that equality and diversity was discussed through the staff appraisal process, team meetings and team events. GPs shared examples of how they used this learning in day to day practice. For example, they told us there were no barriers for homeless patients and workarounds were in place to record contact information should the need arise. The practice was in a market town location, with no nearby temporary campsites. Transport links were limited, which GPs said meant that few homeless people used the practice because there was a specialist GP service in Exeter.

Patient areas of the practice were on the ground floor. The practice had arrangements in place to ensure it was accessible for patients in wheelchairs with ramp access to the side of the premises. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was an accessible toilet next to consultation rooms, which included baby changing facilities and had a call bell system for help if needed. The practice had an audio loop in the waiting room for those with hearing aids. Patient participation group members told us that the waiting area could be made more accessible and planned to look at this with GP partners and the practice manager.

The practice had systems in place to support patients whose circumstances may make them vulnerable. For example, the practice had a register of patients who may be living in vulnerable circumstances, with specific information in individual records about potential risks and support that was needed. This included patients experiencing domestic violence.

Staff told us they tried to fit patients in for appointments if they presented on the day, making appointments accessible. Fifty two patients confirmed this was their experience of the appointment system.

Access to the service

Newcombes Surgery is open from 8.30 am - 6pm Monday to Friday, with clinic sessions running from 9 am to 12.30pm and 1 pm to 5.30 pm. The practice had a sit and wait surgery every day from 11am where patients can turn up

Good

Are services responsive to people's needs?

(for example, to feedback?)

and wait for an appointment without having to prior book it. Home visits were carried out each day by appointment for vulnerable patients who are unable to attend the practice.

Flexible arrangements were offered for working age patients following consultation with patients and appointments are offered before and after clinics into the early evening by arrangement. Repeat prescriptions were prepared for patients and collected at a pharmacy chosen by the patient in Crediton. Patients we met (23) told us that GPs were very flexible, for example a patient told us their GP offered to see them early before morning appointments started as they had work commitments to get to.

During evenings and weekends, when the practice is closed, patients were directed to an OOH (out of Hours) service delivered by another provider. This is in line with other GP practices in the Northern, Eastern and Western clinical commissioning group, which includes an arrangement for the Out of Hours service to take calls from 6pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. New patients were given an information pack when they registered at the practice that included a booklet outlining all the services, names of staff, clinic times and out of hours information. Helpful advice about self-management of minor illnesses was included, for example covering treating ear wax, colds and coughs, indigestion and bruises.

National patient survey data showed overall 90.28% patients at Newcombes Surgery found it easier to get through to the practice compared with the national average of 75.4%. The practice had acted on results from the previous year 2013-2014 regarding the practice opening hours in which 78.75% patients were satisfied with these compared with the national average of 79.83%. Fifty two patients gave feedback in person or in writing at the inspection and told us that the 'sit and wait' daily surgery introduced in the previous 12 months was successful and appreciated by them.

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.

The practice used a triage system and offered telephone appointments for patients. Patients told us their GP usually telephoned them back after morning surgery or in between appointments, which they felt was a good alternative to attending in person for minor issues. There was a good skill mix of staff, including the practice nurse with advanced qualifications including that of independent prescriber. This provided patients with more appointment options and was particularly appreciated by patients with long term medical conditions.

Longer appointments were also available for patients who needed them and those with long-term conditions. For example, patients with learning disabilities and/or mental health needs were offered appointments at quieter times of the day and for longer periods. Counselling services were available on site provided by the local mental health partnership trust. Information was displayed in waiting areas for patients and highlighted they could self-refer to these counselling services if they wished to.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns, which was outlined in the practice information given to new patients as well as on posters in the waiting room and on the website. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice. We looked at complaints received from patients in 2013, 2014 and 2015, all of which had received a prompt acknowledgement and outcome in writing.

The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. For example, the practice had monitored waiting times for appointments following complaints received and introduced the 'sit and wait' surgery as a result of this feedback. GP partners had an overview of complaints being received and the practice had held resolution meetings with patients where needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The 23 patients we spoke with and 29 patients who gave written comments were satisfied that if they did have any concerns these would be investigated. Patients said they would either speak to the receptionists, their GP or the practice manager.

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 clear vision to deliver high quality care and promote good outcomes for patients. All 14 staff we spoke to told us that Newcombes Surgery aimed to provide high quality care and treatment in a responsive way for patients registered with the practice. Staff were clear about their responsibilities in delivering the service and knew the patients extremely well. Details of the vision and practice values were not documented in the practice strategy and business plan. Patients comments in person (23) and in writing (29) demonstrated that they were satisfied with the services received and that staff were kind, caring and responsive when they needed help.

Staff morale was high and there was a low turnover of staff. As a training practice, Newcombes Surgery provided regular placements for medical students from Bristol and Plymouth medical schools for educational purposes. At the time of the inspection, a GP registrar and a F2 doctor were working at the practice. They felt supported and found communication systems effective and felt included in the team. Permanent staff said they felt valued and were encouraged to be innovative to deliver safe and effective care and treatment for patients. The practice team was managed in an open and transparent way.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. All of these were available to staff on the desktop on any computer within the practice. The practice manager verified that they used the NHS information governance tool kit. The tool kit was developed by the Department of Health to encourage services to self-assess so that they could be assured that practices, for example, have clear management structures and responsibilities set out, manage and store information in a secure, confidential way that meets and data protection. We looked at some of these policies and procedures, which included those covering safeguarding, infection control, recruitment all of which had been regularly updated in light of changing guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, a GP partner and practice nurse took the lead for infection control and a GP partner was the lead for safeguarding. All of the staff were clear about their own roles and responsibilities. They all told us they felt well supported, knew there was a whistleblowing procedure and 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 and in some instances better than expected 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. Prior to the inspection, some data for the year 2013-14 showed that the practice had performed slightly worse than the national average. The GP partners, managers and nursing team had agreed a way forward in which each nurse would take a QOF area to lead on with a named GP. For the year 2014-15 there had been significant improvements in performance in the areas identified as a risk, for example the percentage of face to face reviews carried out for patients with Rheumatoid Arthritis had increased from 17% in 2014 to 100% by April 2015. The overall QOF score had improved from 70.2% in April 2014 to 97.2% by April 2015.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. These included systems to monitor the effectiveness of auditing and enabled the practice to consistently drive improvement.

The practice had arrangements for identifying, recording and managing risks. Risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, a fire safety risk assessment had been reviewed in 2015. A fire drill was identified as an area for action and one had been done in May 2015.

Leadership, openness and transparency

Meetings were held regularly and minutes kept and circulated via email to the team. 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. The practice had a 'shut down' day, which was used for team building and training.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, induction policy and management of health and safety

which were in place to support staff. For example, the practice had risk assessed each role and set out the expected standards for pre-employment checks for each position at the practice. This included what was expected should the practice need to use locum GPs and included making checks of the performers list held by NHS England and entries on the General Medical Council register. The GP partners had taken the decision to obtain annual Disclosure and Barring Service (DBS) checks for every member of staff every year. They told us that they believed this is what their patients would want them to do rather than just meeting the legal requirement to obtain this at the point of employment.

Seeking and acting on feedback from patients, public and staff

The importance of patient feedback was recognised and the practice used three methods to do this. The national GP patient survey, in house survey and Friends and family test was used to obtain on-going feedback. For example, the practice had collated comments obtained through the Friends and family test up to April 2015. From this, GPs were able to determine that patient satisfaction was very high. All of the patients commented that they would be extremely likely to recommend the practice to friends and family if they needed similar care or treatment

The practice had a patient participation group (PPG) with 25 members. The membership of this group generally reflected the practice population and included representation of patients from two care homes. The practice was using social media sites such as FACEBOOK to attract comments from younger patients. Face to face meetings had been held and reports were published on the practice website for the years 2013/14 and 2014/15. The practice had acted upon a number of issues raised through patient feedback and included: telephone triage was reduced in favour of sit and wait surgery every day; patient failure to attend appointments had been reduced with introduction of SMS text reminders.

Management lead through learning and improvement

A random selection of four staff files showed that annual appraisal were carried out. Competency was assessed and training needs were identified, present conduct discussed and future plans agreed upon. The practice nurse showed us their portfolio which contained evidence of professional training and reflection on specific issues. Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by a line manager with the appropriate skills, qualifications and experience to undertake this role.

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurse are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, the practice nurse held records of anonymised cervical screening results. This showed that the percentage of all cervical smears rated with an 'inadequate result' was within the safe maximum allowed. The advanced nurse practitioner was an external assessor for the cervical screening service in the area, so mentored and trained practice nurses and GPs within the practice to develop skills and improve accuracy with such testing. She also mentored and trained practice nurses across Mid and North Devon areas, providing support and guidance about current standards to work within. Practice nurses across the area were encouraged to be part of a network of support through the work done by the advanced nurse practitioner.