Coleridge Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Coleridge Medical Practice on 21 April 2015.

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 also good for providing services for the older people, people with long term conditions, people whose circumstances may make them vulnerable, working age people and outstanding for young people and families.

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

We saw several areas of outstanding practice including:

- The practice encouraged young people from the local secondary school to be part of the patient

Summary of findings

participation group (PPG). Teenhealth Group at Kings School had two representatives from each year group who promoted teenage health around the school. Teenhealth sent representatives to the PPG (four students attended last year). They attended meetings to maintain links with the whole PPG group and to encourage ideas about how the practice can work together with them on health issues and health topics.

- The practice were proactive in supporting carers. They put together a small team of staff to raise the profile of carers and the support available to them. This group comprised of a GP lead, practice nurses, healthcare assistants and an administrator. The group met often to discuss issues and share ideas. Coleridge Medical Centre had been asked to share its experience with other practices and encouraged other practices to nominate an enthusiastic GP lead and form a practice carers team. The practice had received an award from the Royal College of General Practitioners (RCGP) for this work.

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. 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 to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from 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.

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 was supported by a very active patient participation group (PPG) who helped with a number of the initiatives to benefit patients, including an improved appointment system, additional services and social interactions for isolated, lonely patients and carers. The practice had reviewed the needs of their local population and engaged with the NHS England local area team (LAT) and clinical commissioning group (CCG) to secure service improvements where these had been identified. It had also worked to provide additional services for patients.

Summary of findings

Changes were made as a result from the patient survey and the PPG. For example a complete redesign of the appointment system was put in place offering 1936 appointments per week (the average for a practice of a similar size is approximately 1120). The new appointment system gave flexibility within it to maximise access, support continuity of care, improve patient flow and waiting times. They offered on the day appointments an telephone calls to any patient who needed it. Any patient who required a longer appointment was able to book one.

The practice had the facilities and equipment to treat patients and meet their needs. There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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. 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Home visits for flu vaccinations and health checks were arranged for older people who struggled to attend the surgery. Carer status was regularly checked to ensure their needs and the needs of the patient were being met and GPs or community nurses visited older people if an urgent appointment was required.

There were specific clinics for older people's health checks. Information on healthy eating and exercise was promoted on the practice website and via leaflets in the surgery waiting room. Caseloads were discussed and altered in order to streamline care for patients at care homes. Each older patient had a named GP. District Nurses and Palliative Care Nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated.

The practice worked to avoid unnecessary admissions to hospital and worked with other health care professionals to provide joint working. The GPs had direct access to a consultant geriatrician for advice on the best treatment and advice, including whether it was appropriate for the patient stay in the community.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. 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.

Equipment was available for any patient to use to monitor their condition at home. For example, the practice had blood pressure monitors and a nebuliser loan schemes in place. Patients with long

Summary of findings

term conditions were provided with care plans that might include just in case medication to avoid emergency admission, leaflets and signposting to online information and lifestyle management groups. For example expert patient, pulmonary rehabilitation groups.

At the time of our inspection in April 2015 there were a total of 366 patients on the avoiding unplanned admissions for vulnerable people scheme. Care plans were in place for 357 of these patients which included information on where the patient wanted to be cared for, information about family and next of kin and other information that was important such as if a partner who cared for them was unwell as this may have increased the chance of an admission for the patient. The plans were reviewed as and when circumstances changed such as a change in health or an admission or change in home circumstances.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

There was a lead GP for safeguarding, they had completed training to level three. They led a six weekly multidisciplinary safeguarding meeting and worked consistently with the school nurse, health visitors and CAMHS to discuss families and individuals who maybe vulnerable. The patient record was flagged and medical records were updated at this meeting. This model was recognised as best practice and had been shared across Devon. The level three experiential learning template was developed within the practice and was then shared with all GP appraisers across NHS England (South West) and then nationally.

Young people from the local secondary school were encouraged to be part of the (patient participation group) PPG. Teenhealth Group at Kings School had two representatives from each year group who promoted teen health around the school. They wore pink on Fridays to identify them as Teenhealth Group members so that students could approach them with health related matters. Students could be signposted appropriately or referred to a member of teaching

Summary of findings

staff for further guidance or pastoral care. Teenhealth sent representatives to the PPG meetings. Four students attended last year to maintain links with the whole group and to encourage ideas about how the practice can work together with them on health issues and health topics. The Teenhealth group also went to the practice to film a visit to the GP surgery (what it looks like, where to go, what to do) which is shown to young adults who may be thinking using the service without their parent/carer. The practice also helped the group with information for the Teenhealth website.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of patients who were of working age or who had recently retired and students.

Routine appointments were available to book up to 6 weeks in advance. These appointments could be booked online or over the telephone.

The reception desk at the practice was open from 8am until 7pm allowing people to call in and make an appointment or pick up a prescription etc before or after work. Appointments were available from 830am to 630pm - Monday to Friday. Telephone consultations with the nurse and or GP were available every day.

There was a well-established patient participation group at the practice who demonstrated that they were constantly striving to recruit new members of working age.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available. Pneumococcal vaccination and shingles vaccinations were provided for patients at risk, either at the practice during routine appointments or at weekends for patients who found it difficult to access the practice during office hours.

The staff took every opportunity to carry out health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medicine reviews. The practice also offered age appropriate screening tests; examples included testing for prostate cancer and cholesterol testing.

Patients who received repeat medicines were able to collect their prescription at a pharmacy of their choice. The practice had an electronic prescribing system in place which sent the approved prescription directly to the chosen pharmacy. This was useful for patients who could not easily access the practice during office hours.

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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. There were no barriers to patients accessing services at the practice. Patients were encouraged to attend health promotion activities, such as breast screening, cancer testing, and smoking cessation.

Staff were trained in how to help patients who did not have a permanent address in the area, whether as temporary residents, migrant workers or the homeless and traveller populations. They were clear on the processes in place for the patient to register as a temporary patient. Practice staff were able to refer patients with alcohol or drug addictions to an alcohol/drug service for support and treatment.

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

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of experiencing poor mental health (including people with dementia). Staff knew how to recognise and manage referrals of more complex health needs and the practice included other health professionals at their practice meetings when required. Patients showing signs of dementia or memory problems were given extra assistance if required such as telephone reminders about appointments.

Patients suffering with dementia and their carers were able to attend the local memory café. The coordinator of this service attended the practice multidisciplinary meetings to enable good consistent communication.

Staff were encouraged to be aware and to raise any concerns should a patient appear dishevelled or forgetful. Patients on regular medication were always invited for a medication review before their prescription was repeated. Information was shared with other health and social care professionals and information and signposting was available through the practice website and leaflets in the surgery.

Counselling and Cognitive Behavioural Therapy was offered in the practice or could be provided in patients home if required.

Summary of findings

What people who use the service say

We looked at patient feedback from the national GP survey from January 2015, when 151 patients provided responses. High levels of satisfaction were seen in the survey responses. For example 92% of respondents described their experience of making an appointment as good. This result compared higher than the local (CCG) of average of 82%. The survey comments showed that patients found the reception staff to be helpful and caring. The practice was said to be very efficient and well run. Patients told us that appointments were easy to access and when urgent care was needed it was immediate and reassuring. Patients said they appreciated having a range of appointment options, which included being able to be seen and treated by nurses.

Sixty patients gave feedback at the inspection, in person (10) or in writing (50). All confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Many of the patients we met said their care was exceptional and outstanding and they had been listened to. Patients appreciated the service provided and told us they had no complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice. They said the building was always clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

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

The practice had an established patient participation group (PPG). They held three monthly meetings and attendees were patient representatives from Ottery St Mary and the surrounding villages covered by the practice. We spoke with a representative of this group. The PPG felt that the relationship with the partners was good and they worked closely with them and had an action plan which was updated at each meeting to review progress with suggestions made. For example, appointment waiting times had been reviewed and there was a television screen in the waiting room which delivered information to patients. This information changed as different clinics were held, for example to information for younger people.

Outstanding practice

- The practice encouraged young people from the local secondary school to be part of the patient participation group (PPG). Teenhealth Group at Kings School had two representatives from each year group who promoted teenage health around the school. Teenhealth sent representatives to the PPG (four students attended last year). They attended meetings to maintain links with the whole PPG group and to encourage ideas about how the practice can work together with them on health issues and health topics.
- The practice were proactive in supporting carers. They put together a small team of staff to raise the profile of carers and the support available to them. This group comprised of a GP lead, practice nurses, healthcare assistants and an administrator. The group met often to discuss issues and share ideas. Coleridge Medical Centre had been asked to share its experience with other practices and encouraged other practices to nominate an enthusiastic GP lead and form a practice carers team. The practice had received an award from the Royal College of General Practitioners (RCGP) for this work.

Coleridge Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP expert and a specialist practice nurse.

Background to Coleridge Medical Centre

Coleridge Medical Practice delivers primary care under a Primary Medical Services contract between themselves and NHS England. As part of the Devon Clinical Commissioning Group (CCG) they are responsible for a population of 15837 patients. The Practice area covers a 5 mile radius of the town of Ottery St Mary and the surrounding villages, hamlets and farms. The practice also has two branch surgeries in nearby villages of Wimple and Newton Poppleford.

There is a team of six GP partners (two female and four male), supported by two salaried GPs and a GP retainer. The total whole time equivalent of permanent GP staff equates to seven.

The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the surgery is closed at the weekends.

Appointments are available between 830am and 630pm Monday to Friday.

The practice has an established patient representation group (PPG). This is a group that acts as a voice for patients at the practice.

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

There were no previous performance issues or concerns about this practice prior to our inspection.

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 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

Detailed findings

- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting Coleridge Medical Practice we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 April 2015. We spoke with ten patients, nine GPs, five of the nursing team and five members of the management, reception and administration team. We collected 50 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.

Good

Are services safe?

Our findings

Safe track record

We found that the practice had systems in place to monitor patient safety utilising a wide range of data and information available to them. Policies and procedures were in place and readily available to staff to report, investigate and act on incidents of patient safety, this included identifying potential risk. All staff we spoke with were aware of the procedure for reporting concerns and incidents, and were actively involved in quarterly significant event meetings, to discuss incidents and take forward learning. We reviewed significant event reports. The investigations and actions taken were clearly recorded as well as changes made to practice when required. For example a patient with the same name as another was given the incorrect prescription. Actions were taken to prevent this happening again and all staff were made aware. We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice. The practice investigated complaints, carried out full clinical audits and responded to patient feedback in order to maintain safe patient care.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events from March-December 2014 The practice manager and the GPs met weekly to discuss all issues that had arisen over the past week. Significant events and incidents were also discussed at the clinical governance meetings held three monthly. The GPs and practice manager considered that as a small team they were able to deal with things very quickly and communication to the whole practice team was always timely and effective. Any verbal information given to staff was followed up by email and staff were given the opportunity to raise questions.

There was evidence that the practice had learned from past significant events, incidents and complaints. These were raised appropriately, for example, with the NHS England local area team as well sharing findings with the relevant staff. Records were completed in a comprehensive and timely manner.

Reliable safety systems and processes including safeguarding

The practice had a detailed child protection and vulnerable adults policy and procedure in place which incorporated information on the Mental Capacity Act 2005. The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. All staff had received safeguarding training which was updated annually.

All the staff we spoke with were able to confidently discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We were given examples of safeguarding concerns being raised with the relevant authorities and how the practice had been involved in managing these concerns. Quarterly safeguarding meetings were held at the practice with a Health Visitor and where required Social Workers to ensure good communication and all parties were up to date with relevant information linked to children and families welfare. If reception staff had any concerns about a patient's welfare while at the practice, they could communicate these to clinicians prior to the patient being seen by the GP or nurse. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff and to encourage continuity of care. All those on the register were discussed at quarterly safeguarding meetings.

We spoke with the lead GP for safeguarding, they had completed training to level three. They lead a six weekly multidisciplinary safeguarding meeting and worked consistently with the school nurse, health visitors and CAMHS to discuss families and individuals who maybe vulnerable. The patient record was flagged and medical records were updated at this meeting. This model was recognised as best practice and had been shared across Devon. The level three experiential learning template was developed within the practice and was then shared with all GP appraisers across NHS England (South West) and then nationally.

A chaperone policy was in place, and notices for patients in the waiting area and consultation rooms. Speaking with

staff who acted as chaperones, they were clear of the role and responsibility. Only clinical staff acted as chaperones. Where a chaperone was declined or accepted the details were recorded within patient's records.

Medicines management

There were clear systems in place for medicine management. If patients required medicines on a repeat prescription these were re-authorised by a GP at least once a year following a medicine review. For patients with long term conditions this was usually at the same time as their annual check-up. All prescriptions were either printed and collected or sent electronically to the pharmacy of the patients' choice. There were checks in place to ensure prescriptions were secure. Reception staff were aware of questions to ask to ensure the security of prescriptions being collected by patients.

We saw there were medicines management policies in place, and the staff we spoke with were familiar with these. We checked the medicines held at the practice. These were all appropriately stored. Medicines to be used in the case of an emergency were available. We saw that these were checked by the practice nurse, were readily available and within their expiry date. There was a system in place to re-order medicines when their expiry date was approaching. Clear records were kept whenever emergency medicines were used.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Training records showed that nurses had received appropriate training to administer vaccines. Controlled drugs were held at the practice and were secured and recorded appropriately. Some medicines and vaccines were required to be kept in a fridge. The fridge temperature was monitored twice daily and records showed they were stored within the correct temperature limits.

Evidence was seen of medicine audits being carried out. The practice was responsive when new advice was received and carried out medicine audits appropriately. We saw evidence that changes to medicine prescribing were made when required. When new patients registered with the practice their electronic records flagged that their medicine must be reviewed when their paper records from their previous practice were received. We saw that where a new patient had regular medicines the GP checked this and made an appointment to see the patient to discuss any changes that may be required.

Cleanliness and infection control

The practice was found to be clean and tidy. The toilet facilities had posters promoting good hand hygiene displayed. All the patients we spoke with were happy with the level of cleanliness within the practice. We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines.These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

We saw staff had received infection control training. All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment.

We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities. Reception staff had access to gloves and alcohol gel if required when receiving samples from patients. We noted spillage kits were readily available behind reception.

The practice only used single use instruments which were stored appropriately and had a system of stock rotation in place. A cleaning company were contracted by the practice to carry out cleaning. We saw there was a cleaning schedule in place which detailed what cleaning would be carried out on a daily, weekly, monthly and less frequent basis which incorporated deep cleaning. The cleaning company audited the cleaning and the office manager carried out spot checks on different areas of the practice to ensure everything was in order.

We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. We saw the dignity curtains in each room were not disposable, however there was a strict cleaning regime in place in line with current infection control guidance. One of the nurses was the lead for infection control. An external infection control audit was carried in November 2011 and all the recommendations made at that time had been implemented.

Good

Are services safe?

Equipment

The practice had systems in place to monitor the safety and effectiveness of equipment. For example, fridge temperatures were recorded to show that correct storage temperatures were maintained. Effective checks were performed on oxygen, gases and the defibrillator. We saw all electrical equipment had undergone portable appliance testing. Water safety, fire safety and other equipment checks had been undertaken with appropriate certification, calibration and validation checks in place.

Staffing and recruitment

Records showed that there was a low turnover of staff at the practice. We looked at four staff records, all of which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, checks of qualifications and registration with the appropriate professional body. Criminal records checks via the Disclosure and Barring Service (DBS) had also taken place. The practice manager held records which showed evidence that the GPs were suitably qualified, had up to date training, had appropriate English language skills and had passed other relevant checks such as with the Disclosure and Barring Service and the NHS Litigation Authority.

This also included the date when GPs and nurses had completed or were due to complete revalidation of their fitness to practice. Copies of medical defence insurance were seen in files, which were valid for the current year. The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only nurses or healthcare assistants had this additional duty and a DBS had been obtained for all of them.

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. There were checks in place to ensure vaccines and other consumables were in date and ready for use. An automatic external defibrillator (AED) was available in the practice. Regular checks on the AED were carried out by staff so they could be satisfied it was available and ready for use in such an emergency. Staff had received training in cardiopulmonary resuscitation (CPR) and use of the AED.

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Staff carried out daily room checks to ensure there were adequate equipment stocks, and out of date items were removed and reported to the managers.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and had an annual update in 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records confirmed these were checked weekly and resealed afterward to show everything was in date.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified in the plan and rated with mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. Fire safety policies and procedures were in place. Information about checks and guidance for staff was in one place and held in reception. A fire risk assessment had been undertaken. Records showed staff were up to date with fire training and regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients had their needs assessed and their care planned and delivered in line with published guidance, standards and best practice such as those published by the National Institute for Health and Care Excellence (NICE) and those from their local commissioners.

We saw minutes of clinical and practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain and update their knowledge. Patients were appropriately referred to secondary and community care services. These patients were discussed during clinical meetings. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches.

Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Practice nurses helped to manage patients with clinical conditions such as diabetes or asthma. The opportunity, during regular assessments of patients over the age of 55 years, was taken to proactively check for other symptoms, for example patients were asked if they had any memory problems. Any issues were then monitored and advice given when appropriate.

There was no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were referred on need, and that age, gender, race and disability were not used as an adverse influence for decision-making. The GPs at the practice were male and female.

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 information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us 35 clinical audits that had been undertaken in the past year. All of these audits had dates factored in to repeat the process and complete a full cycle. The practice showed us an example where a change had occurred resulting from an audit. We saw that an audit regarding the management of coeliac patients had been undertaken to ensure that the current practice used was compliant with NICE guidance. We saw evidence that audit cycle was repeated, management altered and improvements made.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of anti-coagulation drugs and the monitoring of the international normalized ratio (INR) these are the measures of the extrinsic pathway of coagulation. Following the audit, the GPs identified that some competencies for staff that were monitoring INR levels needed formalising. This had been addressed.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 90.5% of patients with diabetes had an annual medication review.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had

Good

Are services effective?

(for example, treatment is effective)

been reviewed by the 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 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 multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, medical emergencies, infection control and information governance. Staff also attended mandatory updates appropriate to their role, for example, wound care and flu. All GPs were up to date with their yearly continuing professional development requirements and had either 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 NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The practice manager kept a record of appraisals and revalidation dates.

All staff underwent an annual appraisal with a GP and the practice manager. During this meeting learning needs were identified and action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example attendance at a study day about diabetes.

All the staff we spoke with told us they felt well supported by the GPs and nursing team as well as by the practice manager and each other. Patients told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and in particular those 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 a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Every GP was supported by an administrator who processed these documents and results to ensure GPs actioned these every day. When GPs were on leave there was a buddy system in place for correspondence and results to be reviewed and actions taken. All staff we spoke with understood their roles and felt the system in place worked well.

Multidisciplinary staff working in the community were invited to join the morning coffee meeting held between GPs and nursing staff at which patients newly discharged from hospital were discussed and actions agreed where necessary. The practice had responsibility for three beds at Ottery St Mary hospital, so patients were frequently transferred there from the main hospital to facilitate their discharge home. GPs from the practice reviewed patients daily at the hospital and within 24 hours of discharge home to ensure they had the appropriate support, care and treatment. Data showed the practice had low rates of unplanned admissions for patients.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Good

Are services effective?

(for example, treatment is effective)

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.

Regular meetings were held throughout the practice. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made.

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets and posters about local services were available in the waiting area.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, the practice supported older patients living in adult social care home and where appropriate the lead GP had met with patients and their advocates to develop a treatment escalation plan for each person. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice supported patients with learning disabilities, some of whom had complex needs and lived in adult social care homes. There was a named GP linked with each patient within each home so that relationships could be developed, helping to reduce any anxiety patients might have. Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of 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.

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 every opportunity for discussing sexual health screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice's performance for cervical smear uptake was 82.2%, which was better than the national average of 81.9%. 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.

Health promotion literature was readily available to patients and was up to date. This included information about services to support them in, for instance, smoking cessation schemes. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients were treated with dignity and respect at Coleridge Medical Practice. Patients told us they felt all conversations with GPs and nursing staff were confidential and told us conversations were always conducted behind a closed door.

Reception staff were respectful and patient. There was a genuine and friendly connection between the reception staff and patients of all ages. Patient experience feedback showed a high degree of satisfaction with the service provided and the attitude towards them by the staff. In the last GP patient survey in January 2015 it showed 97% of patients said the receptionists were helpful.

Doors were kept closed during consultations. There were curtains in consultation rooms which provided a screen between the treatment couch and door to maintain privacy and dignity. To ensure against interruption, and promote patient confidence during treatment or examination, the treatment room door could be locked from the inside should the patient wish. Within consultation and treatment rooms, windows were obscured with blinds or curtains to ensure patient privacy.

The feedback we received from patients and carers showed that the staff and GPs knew the majority of their patients. Patients felt able to go to the practice without fear of stigmatisation or prejudice. The nursing team and the GPs were able to make longer appointments for those patients they knew may need longer because, for example, they had complex needs, were anxious or likely to become agitated if they felt they were being rushed.

The practice registered patients who had no fixed address and were homeless, examples we were given demonstrated that the GPs were prepared to visit patients regardless of where they were residing.

During our inspection the GPs and nursing staff spoke to patients politely. All the patients, carers and family members we spoke with confirmed this was the case on all occasions.

The practice had a volunteer service which worked out of the practice. Staff were able to sign post patients who needing additional help, for example difficulties with transport, loneliness, nail cutting and bereavement.

Care planning and involvement in decisions about care and treatment

The patients we spoke with told us their diagnosis and proposed treatment options were explained to them. They spoke of feeling reassured and safe in the care of the clinical team. Patients told us they felt involved in their care and treatment decisions. These views aligned with the findings of the most recent national GP patient survey results, which found 100% of respondents had confidence and trust in the last GP they saw or spoke to were good at involving them in decisions about their care, and 92% described their overall experience of the practice as good.

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.

For patients with a high risk of hospital admissions, such as some older people and people with long-term conditions, there was evidence of care plans and patient involvement in agreeing these.

Patient/carer support to cope emotionally with care and treatment

A GP patient survey was carried out in January 2015, 151 patients responded. Patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 91% of patients considered they were treated with care and concern during their consultation with the clinical team. The ten patients we spoke with on the day of our inspection and 50 comment cards we received were also consistent with this survey information.

The practice were proactive in supporting carers. They put together a small team of staff to raise the profile of carers and the support available to them. This group comprised of a GP lead, practice nurses, healthcare assistants and an administrator, all of whom had a real enthusiasm for raising carer awareness. Two reception staff were carers champions and had received additional training to identify, engage and support carers. The group was the foundation stone on which the practice had built a successful and highly valued carers support service, which was embedded in the practice's culture. The group met often to discuss

Good

Are services caring?

issues and share ideas, and included Carers' Support Workers and Carers Devon project managers. A member of staff from social services who was in a carer support role also visited the practice to see patients.

Coleridge Medical Centre had been asked to share its experience with other practices and encouraged other practices to nominate an enthusiastic GP lead and form a practice carers team. The practice had received an award from the Royal College of General Practitioners (RCGP) for this work.

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers

to ensure they understood the various avenues of support available to them. The practice had links with a carer support worker who visited once a month. Appointments were available each week for carers to have a health check. This was undertaken by the health care assistants who had an extended appointment of one hour to provide this service.

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 people'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. We saw evidence that the practice management team involved the patient participation group (PPG) in the development of their patient survey and action plans in response to the feedback received.For example a complete redesign of the appointment system was put in place offering 1936 appointments per week (the average for a practice of a similar size is approximately 1120). The new appointment system gave flexibility within it to maximise access, support continuity of care, improve patient flow and waiting times. They offered on the day appointments an telephone calls to any patient who needed it. Any patient who required a longer appointment was able to book one.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the community nurses to receive their influenza vaccinations. All the practice staff pro-actively followed up information received about vulnerable patients. Telephone appointments were offered each day and early evenings as a result of patient request to accommodate those working age people. A patient told us they really valued this service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients with a learning disability. We saw that the practice nurses had devised a special leaflet for these patients which described visually with photographs what the patient could expect when they visited the practice in a step by step format.

The practice had recognised the needs of different population groups in the planning of its services. Staff said no patient would be turned away. Temporary residents were welcomed.

The number of patients with a first language other than English was very low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The practice had level access from the car park to the front door through automatic opening doors. Inside the building, the GP consultation rooms and the treatment rooms were located on the ground floor, providing level access for patients with limited mobility or using a wheelchair.

The premises were modern and purpose built. The seats in the waiting area were differing heights and size. There was variation of seating for diversity in physical health and all chairs had arms on them to aid sitting or rising. There was a television information display in the waiting room to inform patients of practice information and health promotion items. There was also an appointment call screen in the waiting room for patients convenience. The practice premises belonged to the GPs themselves and they were responsible for variations to the building. Audio loop was not available for patients who were hard of hearing but there was a visual patient calling system in the waiting room. There was disabled toilet access and baby changing facilities available.

The practice maintained a register of people who may be living in vulnerable circumstances, and there was a system for flagging vulnerability in individual record. Patients with complex needs were discussed at clinical meetings and they were assigned a named GP, to ensure they received continuity of care.

Access to the service

The practice was open from Monday to Friday, between the hours of 8.00am and 7pm. Appointments were available to be booked up to six weeks in advance and took place between 8.30am and 630pm. Patients were also able to have a telephone appointment with the on call nurse practitioners and the on call GP. Appointments were made if required on the same day if the patient still needed to be seen. Patients were also able to have a telephone appointment on the same day with their own named GP if they were available.

Comprehensive information was available to patients about appointments on the practice website and within the patient leaflet. This included how to arrange urgent

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 and 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.

Most patients, especially younger people, were not worried which GP or nurse they saw, but those with complicated and/or long-term conditions usually tried to see their preferred GP. These patients were appreciative of the reception staff and told us they really helped patients who were regular and known to them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system, which was set out in a complaints leaflet, and was available in the practice and on their website. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at the six complaints received in the last six months and found these were satisfactorily handled, dealt with and responded to in a timely way. There was openness and transparency with dealing with the complaints, and learning from complaints were shared with the staff team.

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, promote good outcomes for patients, teach and train other healthcare professional which was reflected in their ethos. The practice ethos was clearly articulated on their website and in their Statement of Purpose. All the members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

There was a senior management team in place with leadership responsibilities across the practice. All staff had access to the organisation's policies and procedures which were held electronically on a shared computer drive. We looked at a number of policies and procedures and staff explained the process in place to ensure all staff read relevant policies and procedures for their roles. All the policies and procedures we looked at had been reviewed and were up to date.

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. We saw that QOF data was regularly discussed at monthly clinical governance meetings and action plans were produced to maintain or improve outcomes.

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.

The practice held monthly governance meetings. Staff explained there was a clear structure in place to make sure that performance, quality and risks had been discussed.

Staff felt supported in their roles and were able to speak with the practice manager at any given time. They also said they would be happy to speak to any of the GPs if they felt they had any worries. Individual responsibilities were given to each member of staff and opportunities for progression were apparent. Staff felt valued and were rewarded for the good work they provided.

The management team undertook appraisals for the reception, administration and nursing staff on an annual basis. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Doctors received appraisal and had been revalidated through the revalidation process.

Leadership, openness and transparency

We reviewed minutes of team meetings prior to the inspection. These showed meetings were held regularly, at least monthly for the administrative and clinical teams and included trainee and student doctors. 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. GPs and the nursing team held a daily meeting over coffee to discuss any issues. There was an open invitation for community nursing and social care staff to join these if they had any concerns about patients or any other issues. The practice manager was responsible for human resource policies and procedures.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through national and practice surveys, and complaints received. A practice survey was undertaken in January 2012 by an outside agency. It showed an overall satisfaction of 81% of all patient ratings about this practice were "good, very good or excellent". However, there was a dissatisfaction regarding the waiting time for the appointment itself. Appointment satisfaction rated 59% compared to the national average 65% and the waiting time satisfaction was 51%. It was found that a there was a wide variation in times waited in the waiting room by patients sometimes up to more than 20 minutes on average for two GPs. Support was given to those GPs who tended to run late. For example having a longer appointment times (15 minute appointments). The audit was repeated in April 2012 . This showed improvements and almost all GPs had reduced the waiting time for patients. This audit was repeated again in 2013 and the most recent audit being December 2014 and further improvements were seen.

The practice had an active Patient Participation Group (PPG) which has steadily increased in size. The PPG included representatives from various population groups; including different age groups and employment status. The practice responded to feedback and matters raised by PPG members. For example, a television screen has been installed in the waiting room which gives information to

Are services well-led?

Good

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

patients and is able to change to different target audiences, for example younger people. Adaptations had also been made to the building including automatic front doors to the front entrance. In addition consideration was being given to the installation of handrails outside.

The practice had gathered feedback from staff through staff meetings, appraisals and 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. 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

Newly employed staff received a three month induction programme, and were supported by an induction mentor. Induction plans was prepared for new staff, which they had input into developing, and were able to state their learning needs. Staff we spoke with told us they felt well supported in their roles and in their career development. Staff in the practice received annual appraisals, and we saw records that confirmed this. Staff also told us they were able to approach their managers for meetings as needed to discuss any pertinent matters. Coleridge Medical Practice is an approved training practice for GP Registrars. We saw the training report from last Deanery visit in October 2013 it said that Coleridge Medical Practice was a well-established training practice with two experienced trainers.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.