Kingsteignton Medical Practice

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.

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Summary of findings

Overall summary

Kingsteignton Medical Practice is a GP practice providing NHS primary care services for approximately 10,663 patients. The practice is in the town of Kingsteignton in Devon. The practice has a total of nine GPs who are supported by a nursing team and an administrative team. Opening hours are between 8am to 6pm Monday Friday. The practice provides extended opening hours on Monday, Wednesday and Fridays with pre bookable appointments from 7.00 am. Outside normal surgery hours the emergency cover is provided by a Out of Hours service.

Kingsteignton Medical Practice has one location at The Surgery, Whiteway Road, Kingsteignton, Devon TQ12 3HN. We carried out our announced inspection on Wednesday 9 July 2014 of the practice .

Before the inspection, we asked other organisations to share what they knew about this practice. We looked at information from NHS England, South Devon and Torbay Clinical Commissioning Group (CCG), Torbay Healthwatch and the local Health and Scrutiny Board. We talked with 14 patients on the day of our inspection and they were all satisfied with the standard of care, service and treatment they received at the practice. A further 26 patients gave written feedback in comment cards and by email. Patient comment cards were very positive with a recurring themes of safe, effective and responsive care. Staff were said to be kind and caring.

Older patients told us the practice was caring, responsive and attentive to their needs.

Patients with long term conditions highlighted the many clinics held at the practice. Patients talked about feeling involved in their care and treatment and were able to make choices about their care and had been given suitable advice.

Mothers and babies and young patients were pleased with the care and treatment their families received. Parents told us their care and that of their children was thorough at the practice.

Patients of working age population or those recently retired felt recent changes to the appointments system meant it was easier to see a GP when it suited them.

Patients in vulnerable circumstances who may have had poor access to primary care were closely monitored by the practice team. Initiatives such as the partnership with a local patient support group provided patients with additional support when needed. This included assistance with transport, befriending and help with shopping or collecting medicines. Patients experiencing mental health problems told us they felt listened to and supported when they most needed help. Carers of relatives with dementia type illness told us the day to day challenges of this role were recognised and the team at the practice were proactive in offering them support.

Based on patient experiences at Kingsteignton Medical Practice, we concluded the practice was well led, with clear leadership and governance structures in operation. Patients told us they felt the practice was safe, caring and responsive. The practice was effective in the way it provided care to patients. Information we saw and comments we received demonstrated good working relations with other health professionals, organisations and local authorities. Supporting data and documentation we reviewed about the practice demonstrated the practice performed very well when compared with all other practices within the CCG area.

There were two areas for improvement, these relate to risk assessment of administrative staff who may be involved in chaperone duties and access to Mental Capacity Act (2005) training and the content of the adult safeguarding policy.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Patients experienced safe care and treatment at Kingsteignton Medical Practice.

There were systems in place to capture, investigate and report incidents and notify external bodies. Staff understood safeguarding procedures and demonstrated through examples how children and adults had been protected. The practice consistently used this information to learn from incidents and improve standards of safety for patients. The practice had taken steps to ensure that equipment, medicines and the environment in which care was delivered were safe. Recruitment processes were in place which protected patients from the risk of recruitment of unsuitable or unskilled staff. The practice was equipped to deal with emergencies and staff understood emergency procedures.

Are services effective?

Patients experienced care and support that was effective.

Appropriate clinical guidance, standards and best practice were being followed.

The practice had sufficient suitably qualified staff with a broad skills mix to provide a good standard of care. Staff maintained their knowledge and used national guidance to promote best practice in the care they delivered. Audits were used effectively to guide and improve patient care.

The practice worked collaboratively across the service, with other stakeholders and groups led by patients using the services. Patients were provided with information, advice and support to maintain their health or make positive changes to it.

Are services caring?

Patients experienced support and treatment from staff who were kind, caring and attentive to their needs.

Patients told us that staff treated them with respect and understanding, they told us that they were listened to and never rushed by staff. Patients told us their dignity was maintained during examinations and reassurance given throughout. Patient confidentiality was respected. Carers' needs were followed up after initial assessment and they told us they felt well supported.

Are services responsive to people's needs?

Patients experienced responsive care and treatment.

Summary of findings

Patients individual health needs were appropriately responded to at the practice. Patient feedback was regularly obtained. Patients were able to access urgent appointments when they needed one. The most recent patient survey carried out by the practice led to changes being made to the appointments system. Patients said that preferences, such as to see a doctor of the same sex, were responded to where possible. Extended opening hours were provided three days per week with pre-bookable appointments available, which working patients appreciated so they could attend before work.

Patients knew how to make complaints and these were appropriately handled. Shared learning had taken place across the practice and improvements had been made to the services provided.

Are services well-led?

Patients experienced a well led service.

Kingsteignton Medical Practice had well developed governance arrangements in place. All areas were well-led and had a positive impact on patients care and treatment. The clinical leadership structure was embedded and effective.

The culture was open and the practice had mechanisms in place to hear and share information with staff. Patients and staff raised concerns, safe in the knowledge these would be acted upon and improvements made. Morale was very high across all staffing grades.

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

Kingsteignton Medical Practice has a higher proportion of patients aged 65 and over when compared to the national average in England. In addition to this, the South Devon and Torbay Clinical Commissioning Group (CCG) area has higher numbers of older people experiencing dementia and living alone.

The older people we spoke with were appreciative of the care they receive from GPs and nurses. They felt this was supportive, responsive and met their needs. Age related conditions were targeted by the practice and health promotion clinics held for patients to ensure they were appropriately monitored and treated where necessary.

Older patients who were 'vulnerable' due to physical, mental health or social isolation were identified and closely monitored by a named GP at the practice. Additional support was put in place according to individual needs and to help reduce the need for hospital admission. The practice was flexible in the way patients were cared for with home visits prioritised for patients who were frail, housebound and at risk. The practice works closely with a local charity, which was initially set up by the practice. This provides a network of volunteers who provide transport, equipment, befriending and activities. This service was used by mostly older patients registered at the practice who may not be eligible to receive adult social care support and have limited access to family and friends.

In the wider community, the practice worked closely with adult social care services to improve the quality of health of older patients. For example, all the care homes linked to Kingsteignton Medical Practice had a named GP and patients living in the homes were able to be seen in their own home for reviews and ongoing care.

People with long-term conditions

Kingsteignton Medical Practice cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. Patients told us they felt their conditions were well monitored and they were promptly referred to specialists when needed.

The practice worked to the Quality Outcomes Framework (QOF) which is a voluntary incentive scheme for GP practices in the UK,

Summary of findings

rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. Kingsteignton Medical Practice was performing well in enhancing the quality of life for people with long term conditions like chronic respiratory and heart disease, asthma and diabetes.

Mothers, babies, children and young people

Kingsteignton Medical Practice has a higher percentage of patients under 18 years of age when compared with other local practices in the area. Parents told us the triage system introduced at the practice had enabled children to have appointments later in the day so their child's school day was not disrupted. GPs and nurses communicated well with children, reassuring and engaging them during their appointments.

Maternity services were provided by the GPs and the locality midwifery team. There was also a specialist midwifery team who accepted GP referrals for pregnant women who were vulnerable and at risk of harm from sexual or domestic abuse. This team worked closely with the health visitor team to ensure continuity of care after the baby was born. Children and mothers at risk were identified on their patient records.

Health visitors were based at the practice which meant they had regular contact with the GPs and practice nurses. They arranged appointments for child immunisation and these clinics were run weekly.

Systems were in place for GPs to seek advice and support if they had concerns about a child, and to raise a safeguarding alert with a place of safety if they felt the child was in immediate danger of harm. Practice staff were observant for signs of neglect. GPs and health visitors monitored families known to be at risk and worked closely with relevant agencies as needed. They were also aware of the impact of poverty on patients and provided signposting information to various services.

GPs provided family planning services. The GPs offered "same day" appointments for emergency contraception. For women in early weeks of pregnancy, GPs provided care and support for those seeking a termination. Sexual health promotion was provided by the practice, for example, patients under 25 years of age were able to obtain self testing kits to determine whether they had chlamydia so appropriate treatment could be given.

Summary of findings

The working-age population and those recently retired

Kingsteignon Medical Practice had an on line appointments and repeat medicines system, which meant working patients could make arrangements outside of working hours. The practice provided opening hours from 8.30 am to 6pm daily. However, three early morning surgeries were held each week with pre-bookable appointments available from 7am onwards every Monday, Wednesday and Friday. A telephone consultation system was in place and those patients of working age we spoke with and received comments from felt this was as effective as a visit to the practice. They were also confident the GP would see them on the same day if this was necessary.

The nursing team provided routine blood tests and health screening as well as treatment for patients referred to them by the GPs. Staff were opportunistic in offering health checks when patients attended the practice. Information seen in a national tool collecting outcomes showed Kingsteignton Medical Practice had performed well in helping patients to recover from episodes of illness or following injury, which enabled patients to return to work as quickly as possible.

A charity based at the practice provided opportunities for the recently retired to get involved as a volunteer. The practice was promoting the 'Walk this Way' campaign run by the charity and aimed at retired patients to help them achieve a healthy lifestyle through exercise.

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

People in vulnerable circumstances who may have poor access to primary care were well supported by Kingsteignton Medical Practice.

A community hub model is being piloted in Newton Abbot, which Kingsteignton Medical Practice is part of. There is a Community Support Worker (CSW) who supports people to access to a range of support services. The practice demonstrated good communication with the CSW to promptly alert them that patients may be vulnerable or in crisis. Similarly, patients needing additional support were referred to appropriate services. Volunteers providing befriending and other additional support services to patients in need are accessed by staff at the practice. The charity is based at the practice and this has facilitated strong working links to provide the support to patients in need.

Patients with learning disabilities were offered an annual review with the practice nurse who had specific skills in carrying such reviews. Appointments of up to half an hour were provided allowing

patients plenty of time to discuss their health and needs. The practice used easy read and pictoral format leaflets and letters for patients with learning disabilities geared towards an individual's needs.

Some patients registered at the practice were at risk of poor health due to alcohol or drug dependency. Systems were in place for these patients to be monitored by a named GP. There was also a tight control and overview by the practice staff, GPs and local pharmacists on weekly prescriptions for patients at risk of misusing their prescribed medicines.

We did not meet any homeless people using the service, however the practice demonstrated a responsive approach was taken when transient patients attended. Urgent appointments were allocated and practice staff told us they offered information about local charities providing overnight shelter and food. The practice also worked closely with the local food bank and staff were observant of when a patient might need support and referred people to it.

There were a small number of patients using the practice for whom English was not their first language. Some GPs and nursing staff had specific language skills and patients were able to request appointments with them. A telephone transation service was available, however. this was not found to be the most effective means of communicating with patients needing a translator. The GPs recognised that the lack of local translation services posed a risk with regard to ensuring non English speaking patients received appropriate and timely care and treatment. GPs and nursing staff were therefore pro-active in seeking ways to communicate with their patients to ensure they had sufficient information as well as consent for treatment. In most cases patients attended their appointments with a friend or a family member to help with translation. This was recorded on their patient record as well as confirmation of consent to disclose personal health information to the translator.

The practice supports a local care home specialising in the care of Polish elders. Leaflets and letters for patients living at the home were translated into Polish.

People experiencing poor mental health

Kingsteignton Medical Practice offered support and treatment for patients of all ages experiencing mental ill health. GPs had access to the crisis intervention team and also referred people to appropriate local support services for assessment and treatment. Patients experiencing mental ill health were identified on their patient record. Patients who had complex mental health needs had a multi agency care plan in place and saw a named GP each time they

Summary of findings

attended the practice. Staff understood potential risks for such patients and had the appropriate skills to identify and deal with these. Patients told us annual health checks were carried out and appropriate referral made to specialists where necessary.

Patients with anxiety and depression had access to a low intensity counselling service held once a week at the practice. Patients requiring higher level psychological support were referred to Devon Partnership NHS Mental Health Trust through the single point of access for assessment. The mental health support services contact telephone numbers were included in the information pack for locum GPs working at the practice and individual GPs maintained their own lists of contact details.

Summary of findings

What people who use the service say

The practice provided patients with information about the regulatory function of the Care Quality Commission prior to the inspection and advertised our visit on their website and displayed our poster in the waiting room. Our comment box was displayed prominently and comment cards were available for patients to share their experience with
us.

We spoke with 14 patients and collected 19 patient responses from our comments box. We also received seven emails with comments from patients involved in the virtual patient participation group (PPG). The feedback from patients was very positive, they praised the level of care and support they consistently received at the practice. On the day of our inspection patients told us they were satisfied with the practice and found it responsive to their needs.

The patients we spoke with said GPs, GP trainees and nurses were professional, kind and efficient. Patients with long term conditions said they were regularly seen for check-ups at the practice. When referrals to specialists were required, patients told us this was done promptly , for example a parent described the prompt action taken in diagnosing and treating their child who had meningitis and had recovered from it.

Four patient feedback cards highlighted the long length of time waited for a routine appointment. This was also echoed in email responses from three patients. However, all of these patients remarked they were confident that if they needed to see a GP urgently they could. . Staff told us it was difficult to offer complete choice of GP and timely appointments, due to the high demand. Systems were in place to meet the demand for these appointments. The practice had a duty doctor and telephone consultation in place, which was covered by GPs and the nurse practitioner. Patients we spoke with were happy to have the opportunity to speak with a GP or nurse on the telephone. They verified that a call back was received within an hour, discussed their health concerns and immediately offered an urgent appointment if it was necessary. The practice listened to patient comments and changes had been made to the appointment system in response to these.

Areas for improvement

Action the service MUST take to improve

The recruitment and selection process must include carrying out risk assessments for roles where staff have not had their criminal record checked.

Action the service SHOULD take to improve

Staff knowledge and understanding about the Mental Capacity Act (2005) should be increased to further protect patient rights.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice has been pro-active in recognising the pressures on the NHS and adult social care services and the need to reduce emergency admissions to hospital and long-term placements to care homes. Kingsteignton Medical Practice initially set up a voluntary support service in 1997, which obtained charitable status and is situated at the practice. This provides additional support to vulnerable patients who do not yet meet the threshold for adult social care support but need help day to day. The practice advertises the service widely so local patients receive additional support they might need. For example, older patients with limited mobility and unable to use public transport have been able to get transport assistance so they are able to attend appointments at the practice. The practice promptly identifies patients who may be vulnerable, particularly those who have few social networks and secures befriending support for them from the charity.

Kingsteignton Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector, a second CQC inspector and a GP specialist advisor.

Background to Kingsteignton Medical Practice

Kingsteignton Medical Practice is a GP practice providing NHS primary care services for approximately 10,600 patients. Of these patients there is a higher percentage of children and young people under 18 years of age in comparison to other local services. The percentage of patients over 75 years of age is higher than the national average. The practice has a total of nine GPs who are supported by five qualified nurses and three healthcare assistants. There is a large administrative team consisting of a Practice Manager, Patient Services Manager, IT Administrator, Receptionists and Personal Assistants. Opening hours are between 8am to 6pm from Tuesday to Friday. Telephone lines are open 8.30am to 6pm. The practice provides extended opening hours on Monday, Wednesday and Friday from 7am. Emergency Out of Hours cover is delivered by another provider.

Kingsteignton Medical Practice has one location at The Surgery, Whiteway Road, Kingsteignton, Devon TQ12 3HN. We carried out our announced inspection at the practice on Wednesday 9 July 2014.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included information from NHS England, South Devon and Torbay CCG, Torbay Healthwatch and the local council Health and Scrutiny Board. We looked at the 2014 patient survey and corresponding action plan the practice had in place. We carried out an announced inspection on 9 July 2014. During our visit we spoke with staff (GPs, nurses, healthcare assistants, managers and administrative staff) and spoke with 14 patients who used the service. We observed how patients were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 19 comment cards and seven emails where patients and members of the public shared their views and experiences of the service.

How we carried out this inspection

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

- Is it safe?

Detailed findings

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 9 July 2014.

During our visit we spoke with a range of staff, including GPs, nurses and administration staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Safe patient care

Patients we spoke with said they felt safe with staff at Kingsteignton Medical Practice. They said they trusted the abilities of GPs and nurses at the practice. We were provided with six very positive examples of where patients stated they felt safe. These came from comment cards and from conversations we held with patients. For example, a parent described the prompt action of staff at the practice in diagnosing and treating their child with meningitis.

The practice shared serious event audits (SEAs) and serious incidents requiring investigation (SIRIs) with other agencies, so was considered to have a good reporting culture. Systems were in place to consistently monitor performance and where concerns had arisen these had been addressed in a timely way.

There were arrangements in place for reporting safety incidents and allegations of actual abuse which were in line with national and statutory guidance. Information we held highlighted that no statutory notifications had been received from the practice. Changes were immediately made to the incident reporting process to address this to prompt staff when to notify the CQC.

In total we spoke with 18 staff who confirmed they were encouraged to report incidents and were treated fairly when doing so. Staff had shared awareness of key risks and actions being taken to address these.

Learning from incidents

The practice was open and transparent when there had been near misses or when things went wrong and there were examples of changes that had been made as a result of learning. Key senior staff were accountable for managing incident reporting at the practice. An open reporting culture was promoted and acting on learning was seen as a way to improve the service patients received. Clinical audits took place so improvements to patient care could be made. Significant event audits or analysis (SEA) had been conducted following patient safety incidents.

Learning from safety incidents and safeguarding reviews was communicated internally and externally. Clinical meetings were held every month. Minutes for these showed action was taken to improve systems, operating procedures and staff practices as a result of the investigations or reviews. For example, three SEA covered recurring themes around the palliative care of patients with life limiting illnesses and learning had resulted in changes to clinical practice, including closer working with the palliative care team at the local hospital.

Learning from SEAs had been communicated across all the staff groups. Staff groups held meetings at different frequencies either weekly or monthly. Minutes of meetings held since April 2014 showed shared learning and changes to practice. Staff we spoke with described this process as thorough and said this was a two way process of information sharing about potential serious incidents or other concerns.

Shared learning from external agencies was communicated and changes made to clinical practice as a result. The practice had a dedicated member of staff responsible for managing external safety alerts such as those from the Medicines and Healthcare Products Regulatory Agency (MHRA). The practice pharmacist had carried out reviews of prescribing practice and had highlighted specific medicine groups where actions were necessary. These actions had been completed.

Safeguarding

The practice had procedures in place to identify and respond to risks of harm or abuse relating to children and vulnerable adults. The written adult safeguarding proceedure was not as comprehensive as the one for children. However, this did not impact on staff understanding of the steps that should be taken if abuse was suspected. One of the partner GPs was the nominated safeguarding lead, with another GP acting as their buddy when they were not working. We discussed two recent examples of how the practice had identified potential safeguarding risks and responded promptly and appropriately to protect patients at risk. These examples demonstrated staff had a clear understanding of the complexity of issues that could add further risk to potentially abusive situations, such as poor mental health or domestic abuse. All the staff understood the importance of working in partnership with other statutory agencies such as the Multi Agency Safeguarding Hub (MASH) when children were involved. We saw that staff had ready access to information about procedures and the contact telephone numbers for the local safeguarding teams if they needed to raise concerns.

The lead GP responsible for safeguarding had a monthly meeting with the lead community health visitor based at

the practice. Health visitors told us that this practice was very responsive to safeguarding issues. Health visitors used a compatible IT system and GPs and health visitors could access the same on line records and warnings. There were timely exchanges of information about risks and GPs and nursing staff had access to the most up to date information about patients, including children.

The practice had a whistleblowing policy. This informed staff how they could raise concerns with external agencies, such as social services or the police, if they felt that concerns were not being acted upon at the practice. The staff we spoke with were familiar with the policy.

Staff in the practice had completed appropriate safeguarding children and vulnerable adults training. A member of staff had specific responsibility for managing the training register and closely monitored gaps prompting staff when updates were required. The practice's safeguarding lead had recently undertaken updated safeguarding training to the required level for safeguarding children (level 3). They showed us a copy of the course certificate when we met with them.

Monitoring safety and responding to risk

Risk assessments were completed by the practice to ensure the health and safety of patients, visitors and staff. Records demonstrated the practice had taken preventative action in respect of safety risks. Staff received fire safety training on an annual basis. The practice had annual fire risk assessments completed by an independent company. Annual safety checks on the premises and equipment had been carried out and checks had been documented.

The practice staffing establishment was kept under review to ensure patient safety. One member of staff acted as a co-ordinator for staff rotas and clinics. This was overseen by a lead GP who ensured clinical skills and experience matched those rostered for clinics. We were shown forward planning for August 2014, which had been identified as a potential risk due to the number of staff being on holiday. Gaps in the roster had been flagged to the lead GP who had authorised the request for a locum GP to cover routine appointments only. We saw the skill-mix and allocation of staff to specific clinics supported compassionate care and levels of staff well-being. For example, baby immunisation clinics were run by two nursing staff with appropriate qualifications and experience whose competency to undertake these had been assessed.

A 'Virtual Ward' was in place, ensuring close case management of those patients most at risk of being admitted to hospital. GPs reviewed the patients on this list at a monthly meeting, which was also attended by community health workers. Risk ratings were ascribed to each patient, reviewed and altered according to patient needs. Additional support was put in place in response to increased risk. For example, a member of staff in the patient services team described the rapid response of the practice to support a patient who had not been taking their medicines. They worked closely with the community pharmacist and voluntary support service to provide additional support for the patient which promoted better self care and treatment.

The practice had a similar system in place for patients diagnosed with a mental illness. Patients were recalled for routine checks ups annually. In addition, if patients with mental illness failed to attend appointments on three occasions following prompts and reminders, the local mental health team was contacted. If GPs had particular concerns they would alert the community mental health nurse to request that they visit the patient at home.. The practice nurse was very aware of their patients and those likely to be more vulnerable and at risk. The practice had a zero tolerance policy of violence or abusive behaviour by patients, with a system in place to support staff if they encountered such behaviour.

A number of patients misused drugs and or alcohol and many lived with anxiety and depression. The GPs and practice nurses provided opportunistic preventative information in their consultations and provided support with information about lifestyle changes. Practice nurses showed us a nationally recognised tool they used to calculate the potential impact on health with patients who misused alcohol. Information given to patients about lifestyle changes corresponded with the level of risk assessed. Where additional support had been identified the practice had access to an alcohol support worker who worked with patients and families where alcohol dependency was a problem.

Up-to-date emergency medicines and equipment were available for use by suitably trained and competent staff working in the practice. Risks were reduced by the weekly checks carried out to ensure equipment and emergency medicines were viable and in date. Nearly all of the staff working at the practice had completed resuscitation and

Are services safe?

anaphylaxis training within the timescales recommended by the Resuscitation Council. Arrangements were in place for the newest staff to also complete this within the next few months.

The practice had contingency plans to ensure the continuity of the service in the event of serious and ongoing problems with the premises, such as flood or fire. Plans were in place to operate from a nearby practice. The IT lead verified that patient records were backed up remotely providing assurance of their added security.

Medicines management

Adherence to safety and safeguarding systems and procedures were monitored and audited by the practice pharmacist. This followed Royal Pharmaceutical Society best practice guidance. We saw two audits, both of which showed that potential risks associated with specific prescribed medicines had been highlighted to GPs. Safer and less expensive alternative medicines were suggested and the second audit showed reviews had taken place with patients, risks discussed and new alternative medicines prescribed.

GPs said they ensured patients were given information about the purpose of their medicines, potential side effects and monitoring, such as regular blood tests. Patients we spoke with confirmed this. One person told us they had discussed the side effects of their medicine and described how the GP was working with them to find the right treatment that worked for them.

Medicines were secure and stored in a locked room within locked refrigerators. The arrangements for the safe storage of the keys to the refrigerators prevented unauthorised access.

Arrangements ensured the cold chain was maintained for the storage of medicines held at the practice. Records for each refrigerator showed temperatures were checked twice a day. All staff responsible for monitoring the medicines knew the safe temperature range and recorded checks showed these were within that range.

Expiry dates were clearly recorded on medicines and closely monitored by staff to reduce the risk of patients being given out of date medicines, In addition, expiry dates of medicines were also checked every week when new medicine stocks were ordered.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. 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. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

GPs offered support and treatment for patients of all ages experiencing mental ill health. Patients experiencing mental ill health were identified on their patient record and had a comprehensive care plan which was monitored by both the GPs and practice nurses. For example, there were systems in place to ensure that patients who missed appointments for injections were contacted promptly. This early intervention helped to ensure effective treatment for the patients.

Cleanliness and infection control

Patients we spoke with in person or received written comments from were positive about the standard of cleanliness of equipment, premises and consistent use of protective equipment by staff.

Adherence to safety and safeguarding systems and procedures were monitored and audited on a risk basis, and necessary actions were taken as a result of findings. For example, on one the assessor had identified minor issues regarding there not being a mixer tap in some treatment rooms or foot operated pedal bins. The practice manager verified action had been taken to address these issues. Risks associated with legionella were assessed by an external specialist in July 2014 and the practice had implemented verbal recommendations whilst waiting for the written report.

Clinical staff showed us the on-line access they had to national guidance about infection control measures. Risks associated with injury and infection from the handling needles and blades were minimised. Staff that we spoke with were familiar with the practice's policy on sharps and all clinical areas had a suitable sharps bin. Records showed up to date immunisations, including Hepatitis B, to protect staff from risks of contagious diseases.

Are services safe?

Staffing and recruitment

We looked at four staff files which demonstrated the recruitment procedure was followed. Where staff had been recruited from an agency assurances of pre-employment checks had been obtained. One member of staff had returned to the practice after being employed elsewhere, their file demonstrated that the whole process had been repeated, showing all candidates are treated equally. GP and nursing staff files contained evidence of formal qualifications and appropriate health checks including immunisation status, these files also contained evidence of criminal record checks using the Disclosure and Barring Service (DBS). However, no DBS checks had been performed for administration staff and the decision not to do so was not supported by a recorded risk assessment. These staff were sometimes asked to act as chaperones on rare occasions if a nurse or healthcare assistant was not available. A chaperone is a member of staff who acts as a witness when a patient has a medical examination or treatment, so should be subject to the same level of DBS checks as staff who work directly with patients.

All four staff files we looked at had updated contracts containing terms and conditions of their employment. The practice had checked that clinical staff were fit to practice and had current valid registrations that had been checked with General Medical Council and the Nursing and Midwifery Council to ensure they were up to date and had not expired.

Dealing with Emergencies

There were arrangements in place to deal with foreseeable emergencies for patients. For example, training records showed nearly all of the staff had completed emergency first aid training at a frequency associated with their role and responsibilities. Staff we spoke with knew the location of emergency equipment and its uses. Earlier in the year, a patient had collapsed at the practice and had been successfully resuscitated before being taken to hospital by the emergency services.

The nurse practitioner was responsible for ensuring the equipment and emergency medicines were safe and in date. Equipment had been serviced and emergency medicines were in date and there were clear records of this.

Equipment

The practice had arrangements in place to ensure equipment was maintained and safe for patients and staff to use. For example, records showed that portable appliance testing had been completed every two years. Equipment was labelled demonstrating when this testing was last done. Staff told us equipment underwent calibrations which were required on an annual basis and records confirmed this.

Staff told us they felt they had enough equipment to carry out their role effectively and safely, which was well maintained and risk assessed. For example, administrative staff used IT equipment which was regularly maintained through service contracts.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

Patients received care and treatment according to national guidance including guidelines from the National Institute for Health and Care Excellence (NICE) and best practice professional guidelines. Minutes of the weekly clinical governance meetings showed discussion about best practice and subsequent action. Examples included the utilisation of information provided by the medicines optimisation team, (part of the clinical commissioning group) which had enabled the GPs to benchmark their prescribing against other practices in the area; and also how GPs had lowered diagnostic thresholds for patients with osteoporosis, resulting in patients being referred earlier for re-scanning to assess bone density and seeking consultant advice at the same time. They told us patients received more timely assessments and individualised treatment to reduce the risk of bone fractures.

Staff were confident in their knowledge of consent and the importance of the assessment of mental capacity and the application of the law. Staff we spoke with made reference to 'Gillick competency' when speaking about consent issues with children and young patients. This showed staff understood that children under 16 years old who have 'sufficient understanding and intelligence' to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. GPs were clear about their roles and responsibilities promoting patient rights under the Mental Capacity Act 2005 (MCA). The MCA is a framework which supports people who need help to make decisions. Nurses were less clear about the remit of the MCA with regard to identifying when patients living in care settings, but attending the practice for treatment, might be experiencing potential illegal restraint or restrictions

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included individual GP prescribing practice. NICE guidance covering the management of chronic respiratory disease had been fully implemented following a clinical audit. The clinical audit identified a high number of patients with a diagnosis of chronic respiratory disease and at risk of infection had a management plan, including a rescue pack. The rescue packs contain steroid and antibiotic medicines, which patients commenced treatment with when their symptoms change indicating a deterioration in their health that could lead to hospitalisation. At the same time, the audit also identified some patients who had not been prescribed a rescue pack and these were immediately issued to them. Patients had greater control over their treatment, which could be started more quickly and lowered the risk of being hospitalised.

Nurses were also subject to clinical audit cycles. For example, nurses explained that cervical smears were audited and they had to be revalidated every 3 years to carry these out. Results of smear tests for female patients were always checked by the nurse practitioner. 'Inadequate' smear test results led to the patient being recalled and additional audits being triggered for the individual nurse who carried out the test. This ensured the cervical screening service was constantly monitored for effectiveness for patients.

GPs at the practice undertook minor surgical procedures in line with their registration and agreed protocols. The staff were appropriately trained, kept up to date and held evidence for revalidation of their qualifications.

The General Practice Outcome Standards were developed by GPs and used nationwide as a measure of quality of care and treatment for patients. Information from the General Practice Outcome Standards showed that Kingsteignton Medical Practice was achieving higher levels of quality care for patients. This showed the practice was prompt in identifying cancer, heart disease, asthma and diabetes as well as recording smoking status, promoting smoking cessation and flu vaccination with patients.

Staffing

Nursing and health workers had the flexibility to alter the length of appointments offered dependent upon individual patient need. There was a system in place to monitor the skills and availability of nursing staff at the practice. Lead practice nurses showed us rotas and explained changes being made within the team to ensure there was an appropriate skills mix, which was flexible and met patient needs.

Newly appointed staff received an induction which included an explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures. They spent

Are services effective?

(for example, treatment is effective)

time shadowing more experienced members of staff which enabled them to learn their role effectively and safely. Performance reviews were conducted after 12 weeks of employment to make sure the member of staff was suitable for the role and had completed the induction. Ongoing performance reviews for longer serving staff were completed annually and for nursing staff, competency was regularly assessed to undertake specific procedures such as cervical smears. Nursing staff verified they would not be authorised to do such procedures without assurance of competency, which promoted patient safety and effective screening.

GPs and nursing staff kept personal development records and reflective notes for their individual portfolios. They undertook the training they needed to undertake their role and were up to date with their training. This included sourcing relevant training and attending in-house training. For example, a GP showed us their portfolio containing certificates demonstrating they had completed level 3 safeguarding training. The nurse team leader verified that their responsibilities also incorporated monitoring the training needs of the nursing team. For example, we were told that in November 2013 nurses jointly running coronary heart disease clinics with lead GPs completed update training about specific blood tests to monitor coronary patients' health.

GPs and nurses verified that they are individually responsible for maintaining validation with the respective professional bodies such as the NMC (Nursing and Midwifery Council) and GMC (General Medical Council). The practice manager showed us a spreadsheet demonstrating they had oversight of when validation was due to expire and recorded evidence of renewals.

Working with other services

The practice worked with other health and social care providers. For example, district nurses were based at the same premises and spoke highly of the way this practice worked with them. They described a regular flow of information between the services and said the practice responded to patient needs. The practice had established links with all the local care homes in Kingsteignton with a named GP visiting each care home weekly and one care home twice weekly. For example, staff at a specialist care home for older people told us the GPs were always accessible and held two sessions at the care home providing appointments for residents there. Patient health was monitored closely by the visiting GPs. A meeting was held once a month to discuss every patient, which we were told picked up any issues leading to further investigation, review of medication or ongoing referral to a specialist.

Kingsteignton Medical Practice used the same electronic recording system that other local health care providers used. There were systems for management of investigation results such as blood tests. Patient services staff told us they managed the incoming investigation results each day and forwarded these to the relevant GP who had ordered them. GPs told us they were required to check these every day, marking the outcome of the result and actions required. Where an abnormal result was marked, patient services staff could be tasked with recalling the patient for a repeat test. There was a buddy system across the GP group, where decisions about the result was peer reviewed regarding test results.

Continuity of care between the practice and Out of Hours services was recognised as a potential risk for patients at the practice. Systems for sharing key information about patients at risk were effective. For example, within patient records GPs recorded notes which were then sent to the Out of Hours service about patients who were likely to need ongoing support through the night. A few patients in their comments shared their positive experiences of urgent care and co-ordination between the practice and Out of Hours services.

The practice had systems in place to monitor newly discharged patients returning from hospital. A GP provided intermediate care at Newton Abbot hospital for 10 sessions per week. As part of this role, the GP carried out post discharge visits to patients at home. The IT system used by the practice was used by other GP practices in the area so important information about patients at risk could be transferred and support targeted to the individual's needs. The multidisciplinary 'Virtual Ward' meeting held once a month was attended by the GP providing intermediate care at the hospital. We saw several examples of proactive management of patient needs, which tended to be elderly, vulnerable adults, patients with special needs and/or multiple chronic health conditions.

Health, promotion and prevention

Health promotion material was displayed in prominent areas at the practice. Information in the form of pamphlets, large print notices and printed sheets was readily available. The information on display was grouped in themes and

Are services effective?

(for example, treatment is effective)

conditions making it more accessible for patients so they could identify specific information. Health information was also available on the practice website such as how to recognise or prevent illness and manage long term conditions.

New patients were offered regular health checks depending upon the outcome of their initial assessment. Patients we spoke with confirmed that they had been offered checks such as regular blood pressure monitoring, where appropriate.

Support for lifestyle changes and healthy living was provided at the practice. This included support for smoking cessation, changes to dietary habits and support for improved mental health. Two people that we spoke with praised the support they had received with encouragement to healthy living. They told us about the positive outcomes this had for them. One other person told us about the information they had been given to support them to manage a period of depression. They told us they felt extremely well supported in this by being referred for talking therapies and it had a positive result for them.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The verbal and written feedback we received from 40 patients had common themes about their experiences at the practice. They highly praised all of the staff who work at the practice. Patients talked of staff being professional, friendly, helpful and caring. Patients told us staff were respectful and polite.

Patients shared examples of their experiences during times of hardship, bereavement and loss and told us the compassion they were shown had helped them through these times.

Privacy and dignity were respected. At the reception desk patients observed a respectful distance. We observed interactions between reception staff and patients. These were polite and professional. There was appropriate screening in consultation and treatment rooms. Patients said chaperones had been offered and sheets used to protect dignity during intimate examinations.

Involvement in decisions and consent

The practice participates in the annual national Quality and Outcomes Framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. Information we reviewed from the QOF monitoring, indicated the percentage of patients did not yet have a fully documented care plan to which they or their representative had agreed.

Patients told us they felt involved in the decisions about the care and treatment they received and were able to decline treatment. For example one patient spoke of how they had refused counselling and another had chosen not to follow a pathway of care but had been supported by the GP to try an alternative. The nursing team had not received training about the Mental Capacity Act (2005) but knew about the general principles. Patients told us they were asked for their consent before any invasive treatment was provided. One patient said they could not remember whether they had to sign for something or verbally give consent before their child was given immunisations. Another patient said they had signed a form before receiving minor surgery.

None of the 14 patients we spoke with said they had ever felt rushed whilst seeing the GP's or nurses. One patient said they felt the GP really took time to listen.

We did not speak to any patients whose first language was not English. Staff told us there is a large Polish population in the area but their English language was good. There were facilities to access a telephone and face to face translation service should it be required.

The practice and consulting rooms had level access. Staff had risk assessed access for wheelchair and mobility scooter users and the most accessible rooms were available to them.

Everyone working at the practice was expected to sign a confidentiality agreement as part of their contract of work. Patients we asked were not concerned about confidentiality. They were aware their information may need to be shared by the GP or nurse with other healthcare professionals. All staff underwent training on information governance (sharing confidential information).

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice responded to their individual health needs well. They said that preferences, such as to see a GP of the same sex, were responded to where possible. However, a recurring theme in feedback comments from patients was that they could not always see a specific named GP of choice. Although, all of the patients who raised this were aware of the increasing demands on the GPs working in a large practice and the majority felt it would not be practicable to always see the same named GP.

Patients said the prescription system was excellent. Some patients used the on-line request service, whilst others called in to collect theirs and others had a service which delivered direct to a chosen pharmacy. All patients said the process took a maximum of three days and a system was used to remind patients to come in for health checks before further prescriptions would be issued.

Secondary care referral to hospitals or other health providers were made promptly. Patients were able to pick their own routine appointment time through a choose and book system and given information about how to do this before leaving. For urgent referrals to other services GPs completed a template, patient services staff processed it and an appointment was booked. As a result people had an appointment, in most cases, before they left the surgery.

The practice was accessible to wheelchair users. One narrow corridor leading to nurse treatment rooms had been risk assessed to ensure patients using a wheelchair could access this area. Alternative rooms were available for use for patients using wider mobility aids such as a scooter. There was an area where pushchairs could be left.

The practice had a virtual patient participation group (PPG) to increase the opportunity for patients to influence the service. This group was in its infancy and conducted business on-line. We received feedback about the practice from seven members of the group who were looking forward to being involved in future development of the service. They told us they would value having occasional face to face meetings, which were due to start in September 2014.

Access to the service

Patients all said it was easy to get an appointment on the same day. Three patients said the appointment system had improved over the last six months. On the day of our inspection visit, two patients had arrived at the practice without an appointment and were provided with one. Six of the 14 patients we spoke with had phoned during the morning and been given a morning appointment. One patient said they had insisted they came to be checked by a GP and this had been organised without fuss. Another patient said they always requested a female GP and this was also organised.

Patients told us the telephone triage appointment system had taken a while to get used to but worked well. On the day of our inspection eight of the 14 patients had received a same day appointment by using the triage system. The nurse practitioner told us there was a GP and her on each day to manage the calls but three staff were used on Monday mornings when demand was higher.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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. The last audit of complaints was carried out in June 2014 and was shared with NHS England and the CCG. In a twelve month period 27 complaints were received, of which 19 were upheld. The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. These included improved communication with community nurses so pain relief was prescribed and put in place more quickly for patients at the end of their life. Another example had led to staff being more proactive with allergic patients, so the type of flu vaccination used avoided them experiencing an allergic reaction.

None of the 14 patients we spoke with, or patients who gave written comments had ever made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager. One patient asked us why they would need to complain when the service they received was so good.

The main complaint from patients was about the lack of continuity of care. Seven out of the 40 verbal and written comments we received from patients highlighted that each

Are services responsive to people's needs?

(for example, to feedback?)

time they saw a different GP and had to repeat their medical history again. The 2014 patient survey report showed that patient opinion about the GPs and nurses was obtained. The practice had discussed the results with all the staff in April 2014 using this feedback to improve patient experience.

Are services well-led?

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

Our findings

Leadership and culture

There was strong leadership at the practice. Partner GPs provided business and clinical leadership in areas such as safeguarding and specialist care. Staff told us they felt they were well supported and enjoyed working at the practice. The changes and challenges staff faced at the practice related to embedding new IT and appointment systems. Staff said they received good levels of support through these changes. Staff knew how to raise concerns about whistleblowing and where they would report their concerns. Opportunities to give regular feedback and take part in pilots were evident. Care and welfare meetings, access to counselling services and de-briefing after serious incidents were embedded measures supporting staff. The majority of staff told us they felt very well supported.

Staff morale was very high at the practice. Staff said they felt valued and were encouraged to do the best for patients. Staff teams were managed in an open and transparent way at the practice.

Governance arrangements

All sixteen staff understood their role and responsibilities and demonstrated appropriate accountability in the way they supported and treated patients in their care. There were clear lines of accountability with regard to making specific decisions, especially decisions about the provision, safety and adequacy of the care provided and these were aligned to risk.

Senior GPs had lead roles, for example one GP was responsible for the protection of patients. Policies and procedures underpinning Adult and Children safeguarding at the practice were kept under review by this GP and referenced national guidance and current local safeguarding processes. Administrative staff held specific responsibilities for example with regard to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were escalated to the GP prescribing lead and were then discussed with the pharmacist who helped in raising awareness across the clinical team about potential risks and necessary actions to take. In a recent example, the lead prescribing GP had also sought advice from a gastroenterology consultant at the hospital about a specific medicine. The GPs decided to limit the use of this medication because of the potential risks identified in the alert.

The nursing and health worker team were led by a lead practice nurse. The lead practice nurse carries out appraisals and provides mentoring for staff. They themselves were supported through the local practice nurse forum and links with the modern matron at the hospital. The human resources lead GP and practice manager carried out appraisals of the lead nurses.

There were management systems in place to monitor the quality of the service provided. Regular reports were provided to the South Devon and Torbay Clinical Commissioning Group (CCG). This included performance information, clinical and strategic management. Referrals were monitored and there was a quarterly system in place for GPs to check each others referrals, for example, for appropriateness.

There were clear lines of reporting at the practice, which were monitored through quality and safety processes. For example, one of these processes included senior managerial weekly oversight of emerging risks with vulnerable patients. A traffic light system was used to denote level of risks for these patients, which changed accordingly when reviewed. The team had a clear overview of the most vulnerable patients. Immediate, medium and longer term actions were in place to mitigate potential risks and promote patient safety, health and welfare.

Systems to monitor and improve quality and improvement

Clinical practice at Kingsteignton Medical Practice was subject to external peer review and directed audits related to NHS funding. Examples seen included an audit carried out by Torbay Hospital Oncology Team across 11 GP practices, which included Kingsteignton and looked at the effectiveness of diagnosis. The practice used the significant event analysis framework to review randomly selected patients who had a diagnosis of cancer.

The practice participates in the annual national Quality and Outcomes Framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. The practice has to achieve targets called indicators in 25 main sections, called domains. These include clinical care which looks at long term conditions such as asthma and coronary heart disease to make sure the staff are caring for these patients adequately.

Are services well-led?

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

In the main QOF results for the cycle 2012-13 were achieved by the practice. We noted that statistically the practice did not measure as well in some areas for patient care and review. For example, Kingsteignton Medical Practice was rated as "Tending towards worse than expected" for patients with heart failure being admitted to hospital as emergencies. As a result of this, the clinical team had focussed on identification of patients with mental illness who might be at higher risk of developing long term conditions. For example, a patient with bipolar disorder was started on treatment for heart disease following an annual review to identify potential concerns and promote healthy living.

As well as directed audits the practice undertook some internal audits. These included analysis of complaints and feedback from patients, leading to key lessons being shared across the team to improve the service.

GPs met every day to discuss practice issues informally and there were regular formal meetings to promote good communication and team work. These included a weekly meeting for senior clinicians and the practice manager to review risks and issues arising, monthly clinical governance meetings, business meetings and vulnerable patient meetings. There were also separate practice nurse meetings for nursing staff to catch up, share information and feedback.

Patient experience and involvement

The Quality Outcomes Framework (QOF) for 2012- 13, highlighted lower levels of patient satisfaction with regard to overall care and access to appointments. The most recent patient survey in 2014 focussed on these areas, 42 patients responded to the survey, with the results and analysis published on the practice website together with action points. This showed patient satisfaction was slightly improving. The practice had responded by reviewing the appointment system and had introduced book ahead appointments and telephone triage, so patients could discuss their concerns and get a same day appointment if necessary. The report explained the challenges of trying to meet increasing demand, limitations on funding and patient expectations about the service. Patient awareness of the on-line repeat prescription service and other options for queries about medicines or fitness notes was being promoted by information in the waiting area and on the practice website.

The importance of patient feedback was recognised and feedback mechanisms were advertised and easily accessible. The patient participation group (PPG) was in early stages of development but it was used to provide patient voices to influence the service. The practice manager had taken steps to recruit patients from a range of ages and experiences to be part of the virtual PPG. This suited the patient population who were more readily able to access and use email and text messaging as an instant means of communication. The PPG acted as a patient voice and provided feedback to the practice manager and partners. Individual GP surveys were conducted as part of annual appraisals. The practice also monitored feedback via external sources.

Patients said all the staff were polite, friendly and kind. One patient said it looked like a nice place to work. This view was shared by the 16 members of staff we spoke with.

Staff engagement and involvement

Staff said there was a real sense of team and a 'can do' attitude. Staff said the leadership was approachable and supportive.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Team training days were held four times a year, plus a monthly meeting for all staff/partners was held once a month to communicate important issues and provide training.

Learning and improvement

We saw evidence that the practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual clinician level. For example, a GP's contraceptive prescribing had been reviewed. This showed the GP was responsive to patient needs in their prescribing practice. One of the longer term goals for the local CCG is to reduce the level of teenage pregnancies within the Torbay area, so the audit provided the GP with a measure of where their prescribing sat with this. Another example seen was the revalidation of nurses in cervical screening every 3 years. Nurse held records of anonymised cervical screening results, which were peer

Are services well-led?

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

reviewed. All 'inadequate result' cervical smears carried out for patients, were reviewed by the nurse practitioner. Mentoring and support was provided for nurse's to improve their skills and accuracy with such testing.

A random selection of staff files showed they had received an annual appraisal where training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff files 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 their line manager who had appropriate skills, qualifications and experience to undertake this role.

Identification and management of risk

There was a shared vision across the team at Kingsteignton Medical Practice. Staff were motivated and embraced the principles of reflection and review in improving the quality of care and support for patients.

GP partners at Kingsteignton Medical Practice had a clear overview and strategy to manage future business opportunities and risks. The practice had a business continuity plan. It identified the rise in population and a future prediction for a further growth as well as the challenge of recruiting new GPs. The practice maintained an open list when we inspected.

The practice had systems in place to identify and manage risks to the patients, staff and visitors to the practice. Risk assessments had been completed for health and safety risks relating to the building. These had been reviewed and updated.

The practice had a business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work. We were shown the plan which included an agreement to operate from a nearby practice with compatible IT systems if the building became unusable.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice was safe, effective, caring, and responsive for patients who were aged 75 and over. Older patients that we spoke with told us they felt well cared for.

Kingsteignton Medical Practice has a higher proportion of patients aged 75 and over when compared to the national average in England. In addition to this, the South Devon and Torbay CCG area has higher numbers of older people experiencing dementia and living alone.

Older patients were appreciative of the care they receive from GPs and nurses. They felt this was supportive, responsive and met their needs. Patient care reviews took place with the individual and, where appropriate their carer in line with national guidance. Age related conditions were targeted by the practice and health promotion clinics held for patients to ensure they were appropriately monitored and treated where necessary.

Older patients who were 'vulnerable' due to physical, mental health or social isolation were identified and closely monitored by a named GP at the practice. Additional support was put in place according to individual needs and to help reduce the need for hospital admission. The practice was flexible in the way patients were cared for with home visits prioritised for patients who were frail, housebound and at risk. The practice initially set up a voluntary support service in 1997, which obtained charitable status. This charity provides a network of volunteers who provide transport, equipment, befriending and activities. This service was used by mostly older patients registered at the practice.

Staff had good knowledge about the needs of older people and the potential impact on family members caring for them. Carers needs were regularly reviewed. Assistance was given about accessing additional support so they were able to continue looking after family members safely.

In the wider community, the practice worked closely with adult social care services to improve the quality of health of older patients. For example, all the care homes linked to Kingsteignton Medical Practice had a named GP and patients living in the homes were able to be seen in their own home for reviews and ongoing care.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

Kingsteignton Medical Practice cared for patients with long term conditions including asthma, diabetes, and heart disease.

Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. Patients told us they felt their conditions were well monitored and they were promptly referred to specialists when needed.

The practice worked to the Quality Outcomes Framework (QOF) which is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. Kingsteignton Medical Practice was performing well in enhancing the quality of life for people with long term conditions like chronic respiratory and heart disease, asthma and diabetes.

All six of the patients we spoke with who had a long term condition said they felt confident in the care and treatment they received for their conditions. One patient told us how they had moved to the practice because they heard that one of the GPs had a special interest in respiratory medicine.

All six patients said they had been invited to designated clinics for their conditions or had encouraged to attend specialist clinics at the hospital. Patients talked about feeling involved in their care and treatment, were able to make choices about their care and had been given suitable advice. Patients said they had been automatically been called for health checks and routine screening appointments. For example annual blood checks and invitations to attend influenza clinics.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

Kingsteignton Medical Practice has a higher percentage of patients under 18 years of age when compared with other local practices in the area.

Parents told us the triage system introduced at the practice had enabled children to have appointments later in the day so their child's school day was not disrupted. GPs and nurses communicated well with children, reassuring and engaging them during their appointments.

Maternity services were provided by the GPs and the locality midwifery team. There was also a specialist midwifery team who accepted GP referrals for pregnant women who were vulnerable and at risk of harm from sexual or domestic abuse. This team worked closely with the health visitor team to ensure continuity of care after the baby was born. Children and mothers at risk were identified on their patient records.

Health visitors were based on the practice premises which meant they had regular contact with the GPs and practice nurses. They arranged appointments for child immunisation and these clinics were run weekly at the practice.

Systems were in place for GPs to seek advice and support if they had concerns about a child, and to raise a safeguarding alert with a place of safety if they felt the child was in immediate danger of harm. Practice staff were observant for signs of neglect. GPs and health visitors monitored at risk families and worked closely with relevant agencies as needed. They were also aware of the impact of poverty on patients and provided signposting information to various services.

GPs provided family planning services. The GPs offered "same day" appointments for emergency contraception. For women in early weeks of pregnancy, GPs provided care and support for those seeking a termination. Sexual health promotion was provided by the practice, for example patients under 25 years of age were able to obtain self testing kits to determine whether they had chlamydia so appropriate treatment could be given.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

Kingsteignon Medical Practice had an on line appointments and repeat medicines system, which meant working patients could make arrangements outside of working hours. The practice opening hours were from 8.30 am to 6pm daily. However, three early morning surgeries were held each week with pre-bookable appointments available from 7am onwards every Monday, Wednesday and Friday. A triage system was in place and patients of working age we spoke with and received comments from felt this was as effective as a visit to the practice. They were also confident the GP would see them on the same day if this was necessary.

The nursing team provided routine blood tests and health screening as well as treatment for patients referred to them by the GPs. Staff were opportunistic in offering health checks when patients attended the practice. Information seen in a national tool collecting outcomes showed Kingsteignton Medical Practice had performed well in helping patients to recover from episodes of illness or following injury, which enabled patients to return to work as quickly as possible.

A charity based at the practice provided opportunities for the recently retired to get involved as a volunteer. The practice prompted retired patients to get involved in the 'Walk this Way' campaign run by the charity to promote a healthy lifestyle through exercise.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice was safe, effective, caring and responsive for people in vulnerable circumstances.

People in vulnerable circumstances who may have poor access to primary care were well supported by Kingsteignton Medical Practice.

A community hub model was being piloted in Newton Abbot, which Kingsteignton Medical Practice is part of. There was a Community Support Worker (CSW) who supported people to access a range of support services. The practice demonstrated good communication with the CSW to promptly alert them that patients may be vulnerable or in crisis. Similarly, patients needing additional support were referred to the charity at the practice.

Patients with learning disabilities were offered an annual review with the practice nurse who had specific skills in carrying such reviews. Appointments of up to half an hour were provided allowing patients plenty of time to discuss their health and needs. The practice used easy read format leaflets and letters for patients with learning disabilities geared towards an individual's needs.

Some patients registered at the practice were at risk of poor health due to alcohol or drug dependency. Systems were in place for these patients to be monitored by a named GP. There was also a tight control and overview by the practice staff, GPs and local pharmacists on weekly prescriptions for people at risk of misusing their prescribed medicines.

We did not meet any homeless people using the service, however the practice demonstrated a they have systems in place to respond to the needs of transient patients attending the practice. Urgent appointments were allocated and practice staff told us they offered information and support to find warmth, shelter and food. Information about local charities providing overnight shelter and food was given to homeless patients. The practice also worked closely with the local food bank and staff were observant of when a vulnerable patient might need support and referred people to it.

There were a small number of patients using the practice for whom English was not their first language. Some GPs and nursing staff had specific language skills and patients were able to request appointments with them. A telephone translation service was available however this was not found to be the most effective means of communicating with patients needing a translator. The GPs recognised that the lack of local translation services posed a risk with regard to ensuring non English speaking patients received appropriate and timely care and treatment. GPs and nursing staff were therefore pro-active in seeking ways to communicate with their patients to ensure they had sufficient information as well as consent for treatment. In most cases patients attended their appointments with a friend or a family member to help with translation. This was recorded on their patient record as well as confirmation of consent to disclose personal health information to the translator.

The practice supports a local care home specialising in the care of Polish elders. Leaflets and letters for patients living at the home were translated into Polish.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

Kingsteignton Medical Practice offered support and treatment for patients of all ages experiencing mental ill health.

GPs had access to the crisis intervention team and also referred people to appropriate local support services for assessment and treatment. Patients experiencing mental ill health were identified on their patient record. Patients who had complex mental health needs had a multi agency care plan in place and saw a named GP each time they attended the practice. Staff understood potential risks for such patients and had the appropriate skills to identify and deal with these.

Patients told us annual health checks were carried out and appropriate referral made to specialists where necessary.

Patients with anxiety and depression had access to a low intensity counselling service held once a week at the practice. Patients requiring higher level psychological support were referred to Devon Partnership NHS Mental Health Trust through the single point of access for assessment.

The mental health support services contact telephone numbers were included in the information pack for locum GPs working at the practice and individual GPs maintained their own lists of contact details.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person must – (1) (a) operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character (b) ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate. How the regulation was not being met: Patients and others were not fully protected against the risks associated with unsafe or unsuitable staff because the practice had not carried out DBS checks for administration staff and the decision not to do so was not supported by a recorded risk assessment. Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.