Richmond Medical Centre

Quality Report

Moor Lane,
North Hykeham,
Lincoln,
LN6 9AY.
Tel: 01522 500240
Website: www.richmondmedicalcentre.org.uk

Date of inspection visit: 8 May 2014
Date of publication: 24/10/2014

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.

Summary of findings

Contents

Summary of findings

Overall summary

The Richmond Medical Centre provides general practitioner services to a population of approximately 8,750 patients in West Lincolnshire. The practice provides for patients living in North Hykeham, South Hykeham and in the surrounding villages of Whisby, Thorpe on the Hill and Eagle.

The practice manager had a reflective approach to their work which involved regular critical analysis of the performance of the practice. The provider listened to patient comments and had used feedback to improve their service. The practice had effective systems in place to help protect people from avoidable harm and abuse. There were effective systems for the oversight of the practice including medicine management. The building was visibly clean.

Clinical decisions followed best practice. The services were safe and effective. The staff had access to research based practice materials such as the National Institute for Health and Care Excellence (NICE) guidance. The practice worked collaboratively with other agencies and health care teams including specialist consultants, district nursing services, mental; health teams and local care homes.

The feedback we received from all patients was mainly positive. The clinical team gave examples of how they considered patients views about the way the practice was run and with regard to their individual health needs and treatments.

Patients told us their urgent needs were met in a timely way by the practice but a majority also said that the appointment booking system could present delays and be frustrating. A range of appointments were available, including routine and urgent appointments and telephone consultations. People could book appointments either in person, over the phone or on-line.

There was an open culture at the practice and a clear complaints process and effective patient feedback system in place. There were effective systems in place to monitor the quality of the services provided. Governance and risk management measures were in place and staff took action to learn from any incidents that occurred within the practice.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The service was safe.

The practice manager had a reflective approach to their work which involved regular critical analysis of the performance of the practice. They demonstrated a commitment to make changes where necessary where this improved outcomes for patients.

The practice had effective systems in place to help protect people from avoidable harm and abuse. There was an open culture of reporting within the practice and the staff members understood their responsibilities to express any concerns they had. This helped to ensure that patients were adequately protected.

Patients told us they felt well cared for and said that they found the practice was responsive to their needs.

Are services effective?
The service was effective.

The staff had access to research based practice materials such as the National Institute for Health and Care Excellence (NICE) guidance. They had achieved an award following an accredited programme of quality monitoring which showed the practice was open to external scrutiny and willing to learn.

The practice worked collaboratively with other agencies and health care teams including specialist consultants, district nursing services, mental; health teams and local care homes. This showed that the practice supported and engaged with other professionals with the intention of delivering co-ordinated care and treatment.

Are services caring?
The service was caring.

The feedback we received from all patients we spoke with was mainly positive. They said they felt they were supported by a friendly and caring staff team and received dignified care. Patients told us they felt well cared for and that that the practice was responsive to their needs.

The clinical team gave examples of how they considered patients views about the way the practice was run and with regard to their individual health needs and treatments. Those patients we asked confirmed this was the case. They said they were given enough

Summary of findings

consultation time with the GP or practice nurses and they were listened to. This showed that patients received information about their condition and where possible had options about their care and treatment.

Are services responsive to people's needs?
The service responsive to people's needs.

The services were planned and delivered in partnership with other organisations to meet the diverse needs of the local population.

Patients told us their urgent needs were met in a timely way by the practice but a majority also said that the appointment booking system could present delays and be frustrating. The practice had responded to this by having three different ways to book an appointment.

There was an open culture at the practice and a clear complaints process and effective patient feedback system in place. This showed that the practice encouraged the involvement of patients in decisions about the planning and organisation of their services. They learned from the experience of patients and adapted their practice with the intention of improving the quality of care.

Are services well-led?
The service was well-led.

The leadership at the practice was open and transparent and willing to take advice to improve. They were supportive of staff and encouraged their professional development.

There were effective systems in place to monitor the quality of the services provided. There were clear structures and lines of accountability in place to manage and support the staff team. There were strong clinical governance systems in place.

Staff members said they felt valued and proud to work at the practice.

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

Health checks were completed for patients under the age of 75 years and who had not had a consultation in three years, and for patients over the age of 75 every year. The practice was attempting to capture information about older people and others who had caring responsibilities. Referrals had been made to other services to help support people in their own home with the intention of preventing unnecessary hospital admissions or placements in care homes. The practice worked closely with other healthcare professionals to provide a coordinated approach to the care of older people within the community.

One patient was pleased with the support they received when a relative was terminally ill. They said they had been touched by the kindness shown to them after their relative died. A GP visited them to check how they were coping and to find out if they needed any additional support.

People with a hearing impairment could book an interpreter for their appointments. There was also a hearing loop system installed at the practice to support communication with people with hearing loss.

People with long-term conditions

The Richmond Medical Centre monitored people with long term health conditions. This included heart disease, chronic obstructive pulmonary disease (COPD) and diabetes. They had systems in place to recall patients to the practice for regular healthcare reviews. Patients told us that reviews of their care were effectively managed and coordinated.

Mothers, babies, children and young people

The practice worked closely with the midwifery service. They held regular inter-disciplinary meetings and we were told there was effective communication and collaborative working between the two teams. The midwife said patients could make their own appointments with them and appropriate services were provided at the surgery to facilitate this.

We found there were effective arrangements in place to manage and monitor the childhood vaccination programme. The practice nurse regularly liaised with health visitors who then visited children at home if necessary.

Summary of findings

We were told how the practice supported young adults using the 'C' card scheme which is a scheme that offers confidential advice to help young people make safe choices about their sexual health.

The working-age population and those recently retired

We found that additional systems had been put in place to support working age patients to obtain appointments or to have discussions with a GP about their health care needs. People over the age of 45 were offered health checks to calculate cholesterol levels and the future risk of heart attack and stroke amongst other tests.

There was a range of information available to patients on health promotion, family services and translation for people from different minority ethnic groups to support patients who did not speak or understand English.

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

The practice kept a register of people who had a learning disability who lived in a variety of support living situations. One healthcare patient, who was also a carer for people with a learning disability told us the practice staff treated patients with a learning disability with respect and always spoke with them before checking information with the carer if necessary. The practice staff had access to a range of guidance materials and advice about communicating with people with a cognitive impairment which they had found very useful.

Consideration was given to ways in which annual health checks of patients with a learning disability could meet their specific individual needs and they consulted with family carers or support workers to highlight particular access needs.

People experiencing poor mental health

The practice supported people with mental health needs. They maintained a register of people who experienced depressive illnesses. This was flagged in their electronic records and meant the practice could monitor them and offer appropriate support and treatment. They worked with their local community psychiatric nurse (CPN) service and other related agencies to support the provision of a coordinated service to patients with mental health needs.

Summary of findings

What people who use the service say

We met with the chairperson of the Patient Reference Group (PRG) which is a patient led group that works with the practice to improve services. They told us they had a 300 strong membership who could at times become involved in working groups exploring specific issues which were relevant to the running of the practice.

The PRG told us that they felt involved as equal partners at the practice. They regularly engaged with the management at the practice and met frequently as a group. The PRG carried out their own survey at the end of 2013, which showed that most patients were satisfied with their care and treatment and they were adapting to changes which had been introduced in response to previous surveys and feedback.

We saw that the findings from the GP NHS patient survey carried out in 2013 gave an overall patient satisfaction rating of 81% which was slightly less than the national average of 84%.

The patients we spoke with and those who completed our comment cards were all complimentary about the care provided by the clinical staff and the overall efficiency and friendliness of all staff. Patients told us that the staff treated them with dignity and respect.

All of the 17 patients we received feedback from at our inspection said they were satisfied with standards of patient care. The majority said the GPs were thorough and considerate and allowed patients enough time to listen to their health concerns and other issues. Six of the 17 patients did not experience a problem making appointments. Others said they sometimes had difficulties and a minority thought this was a significant problem. The practice had responded to patient feedback by introducing three different systems to make an appointment. The most recent survey tested how well these systems were working and a total of 116 out of 131 of respondents said they were satisfied with the triage system and it had provided them with the treatment they needed.

We received other consistent feedback from patients about their experience of the practice which was that they received an efficient, welcoming and safe service from clinicians and other staff.

Areas for improvement

Action the service COULD take to improve

Significant event analysis (SEA), which is a process where patient safety incident are reviewed and learning, takes place to identify the strengths and weaknesses in the care that is provided. The practice could take steps to systematically review all SEA's in a way that would enable the practice to be satisfied that the desired changes had been brought about and that no errors or incidents of a similar nature had occurred.

Some staff had developed skills to become healthcare assistants (HCA) and provided direct care to patients. They were mentored by a member of the clinical staff team during their training who signed them off to work independently once they had achieved an acceptable standard of practice. The practice could take steps to improve the recording process to confirm that the HCA had reached an acceptable level of competence before they were signed off. The staff confirmed there were periodic checks made to make sure HCA's continued to practice at the agreed standard but records were not kept of this.

There was a subtle change in the floor level in one corridor and a notice displayed at the side warned patients that this was a trip hazard. Although risks had been assessed, the notice itself may not adequately control the risk. The practice could improve the signage to minimise the risk.

Richmond Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

A team of two Care Quality Commission (CQC) inspectors, a GP and a practice nurse manager inspected the regulated activities of treatment of disease, disorder or injury; diagnostic and screening family planning and maternity and midwifery services at this practice.

Background to Richmond Medical Centre

The Richmond Medical Centre provides general practitioner services to a population of approximately 8,750 patients in West Lincolnshire. The practice provides for patients living in North Hykeham, South Hykeham and in the surrounding villages of Whisby, Thorpe on the Hill and Eagle. They have successfully managed a sudden, large increase in the number of patients registering with them after a nearby practice closed in 2012.

The data we saw before the inspection showed us that the Richmond Medical Centre had a higher than average number of patients who were older than 65 years registered at the practice. The largest minority ethnic patient group served was Eastern European.

The practice was open from 8am to 6.30pm Monday to Friday and extended opening hours were offered for one evening each week until 8pm.

The practice provided the regulated activities of treatment of disease, disorder or injury; diagnostic and screening; family planning and maternity and midwifery services. Minor surgery was also provided but not the type that would require registration with the CQC. Those patients who required more complex surgery were referred to a Community Surgery Scheme which was commissioned by the Lincolnshire Clinical Commissioning Groups.

The current practice building was in need of updating and planning permission had been agreed for a new purpose built practice to be developed on the same site during 2015. The practice had systems in place to manage the risks the building presented.

Why we carried out this inspection

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

How we carried out this inspection

The inspection team was led by a CQC inspector. The team also included a doctor who worked as a GP, a NHS manager with extensive experience of work in primary medical services and a second CQC inspector.

We spoke with 17 patients from different population groups and used surveys and questionnaires to gather information on the experiences of patients who used the service. We also contacted five local care homes and spoke with a range of external professionals who work alongside the practice to support patients' healthcare needs, to find out what their views of the practice were. We met with the

Detailed findings

practice manager, all five GPs, three nurses, the phlebotomist and all of the reception and administrative staff to find out how they ensured the practice was safe, effective, caring, responsive and well-led.

We used an analysis of the data available to us to highlight areas of potential risk across five key areas.

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

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

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 a mental health problem.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 8 May 2014. During our visit we spoke with a range of staff including the practice manager, five GPs, three nurses, the phlebotomist and all of the reception and administrative staff. We spoke with 13 patients from different population groups and used five comment cards and information from larger patient surveys to gather information on the experiences of patients who used the service.

Are services safe?

Summary of findings

The Richmond Medical Centre was safe.

The practice manager had a reflective approach to their work which involved regular critical analysis of the performance of the practice. They demonstrated a commitment to make changes where necessary where this improved outcomes for patients.

The practice had effective systems in place to help protect people from avoidable harm and abuse. There was an open culture of reporting within the practice and the staff members understood their responsibilities to express any concerns they had. This helped to ensure that patients were adequately protected.

Patients told us they were well cared for and said that the practice was responsive to their needs.

Our findings

Safe patient care

The practice had quality monitoring systems in place which helped them to recognise and manage risk and which was used for the purpose of bringing about improvements in patient care.

The practice had systems in place to monitor the service and ensure it maintained patient safety. The data we saw showed they had a track record for maintaining patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that their systems and processes to identify and report incidents were effective. From our discussions we found that the GPs and practice nurses were aware of the latest best practice guidelines and had incorporated this into their practice.

All of the staff spoken with knew that they had an obligation to report any concerns they had including errors and near misses. Near misses are events that could have resulted in injury or ill health. They knew about the whistle blowing procedures and told us they were encouraged and supported to report risks and things that had gone wrong. We saw one example where the practice manager had acted on the concerns expressed by a member of staff.

Learning from incidents

The practice used the outcome from significant events to promote learning in the practice. Records had been kept about how the staff team had responded when things had gone wrong. Information came from different sources, including feedback from patients who used the service and from clinical audits and by learning from their analysis of significant events. Significant event analysis (SEA) enables practices to learn from patient safety incidents and identify the strengths and weaknesses in the care they provide.

We saw that the majority of SEA processes had been fully and comprehensively completed and had been discussed at relevant team meetings. We brought one incomplete SEA to the practice's attention and after the inspection they contacted us to confirm they had discussed this at a clinical meeting. They also sent us the outcome of a review they had completed on minor surgical procedures which confirmed if their learning from a related SEA had been effective. We found that more could have been done to

systematically review all SEA's in this way as this would enable the practice to be satisfied that the desired changes had been brought about and that no similar errors or incidents had occurred.

Safeguarding

Prospective staff went through a thorough recruitment process which meant that as far as possible, the practice could be assured that the staff they employed were suitable to work with patients. We looked at the processes in place to ensure that patients were appropriately protected by robust and safe recruitment practice. We found that proper steps had been taken to obtain and verify pre-employment checks. These included Disclosure and Barring Service (DBS) checks which are criminal record checks for all staff including those whose role did not legally require such rigorous consideration.

Staff members were aware of their responsibilities in protecting patients. They could describe how their training had prepared them to recognise signs of abuse and situations where patients may be vulnerable. All of the staff we asked knew about safeguarding vulnerable adults and children procedures and what their responsibilities were to help protect patients from abuse.

Monitoring safety and responding to risk

A review of staffing levels had taken place after the sudden increase in patient numbers following the closure of a neighbouring GP practice. Some staff from the practice which closed were subsequently recruited to work at Richmond Health Centre to manage demand and this provided continuity for those patients who had been affected by the closure.

We found that safety issues were discussed between team members and learning was shared. Checks were made that learning was acted on. We saw that many of the practice staff were nominated as the main contact and had the lead responsibility for one or more aspects of management and safety. These included infection control, health and safety, complaints management and patient liaison among others. This showed a whole team approach toward the management of risk.

The practice worked with other primary healthcare teams toward improving patient safety and they used information from different sources to measure and understand safety issues in the practice. The staff members spoken with confirmed that information on safety incidents and lessons learned had been shared with them and with other GP practices if this was appropriate. The staff described the actions taken to alert them to the presence of a risk. One way of doing this was to apply a 'red flag' to the records of newly registered children who were under the age of three as part of the learning from a significant event analysis (SEA). Some particularly ill patients were also flagged as requiring special access to the services at the practice to support their needs. Staff members told us this system worked well as a means of providing additional safeguards to patients.

We saw that the practice had procedures in place to deal with potential medical emergencies. All staff had received training in basic life support and knew the whereabouts of the defibrillator, which appropriately trained staff were authorised to use. A defibrillator is a machine that delivers an electric shock to the heart when someone is having a heart attack. We saw that expiry dates and safety of emergency equipment and drugs were regularly checked by nominated staff. Different staff members talked us through the action they would take in response to emergency situations. This included ensuring the patient had urgent access to a clinician if necessary. This provided us with assurances that staff members were appropriately trained and well informed about how to access prompt medical assessment and treatment in response to patient needs.

Medicines management

The practice had arrangements in place to handle medicines safely, securely and appropriately. Clear procedures were in place for medicines management which included safe storage and prescribing. Patients had a choice of ways to obtain their prescriptions and we saw how staff supported them in this process. Repeat prescriptions included a medication review date and patients were required to show identification to collect their prescriptions for controlled drugs. Prescribing staff had access to clinical and prescribing guidance.

We saw that the doctor's bag which was taken by GPs on home visits contained a range of commonly used medicines that were in date. The practice did not keep a stock of controlled drugs, which are drugs that are controlled under the misuse of drugs legislation.

Guidance was followed to reduce the risk of compromising the quality, efficiency and safety of vaccines and refrigerated medicines using an effective 'cold chain.' A cold

chain describes the management of temperature-sensitive medicines and how they are monitored from supply to the point of use. The staff members we spoke with about this understood the action that must be taken if the fridge temperature fell outside the normal readings. We checked records and these showed fridge temperatures were monitored twice daily.

Cleanliness and infection control

The practice was visibly clean and hygienic and the practice had systems in place to control the spread of infections. There was a named cleanliness and infection control lead whose job it was to ensure that the policies and procedures for infection control, the safe handling and disposal of clinical waste and dealing with spillages were properly implemented. The staff told us protective clothing was provided and they knew about safe hand washing procedures. There were daily, weekly and monthly checklists in place to record actions taken to keep the practice clean and to monitor standards.

We saw that reception staff took receipt of sample bottles brought into the practice by patients. We saw that patients placed these directly into a receptacle which meant staff handled these as little as possible. The staff confirmed they had received training in cleanliness and infection control and they could recall the key risks and responsibilities. The policy arrangements for the management of clinical waste were being implemented. There was a separate designated room for treating people with known or suspected infections to be seen by clinicians.

Staffing and recruitment

A review of staffing levels had taken place after the sudden increase in patient numbers following the closure of a neighbouring GP practice. Some staff from the practice which closed were subsequently recruited to work at Richmond Health Centre to manage demand and this provided continuity for those patients who had been affected by the closure. Comments from the staff and from patients suggested there were enough staff with the right skills to meet the needs of the practice. This was under review in preparation for moving to the new build surgery which will have additional resources to enable an extension of the services offered.

Dealing with Emergencies

We saw a copy of the practice's business continuity plan which described the actions they would need to take to maintain services in an emergency situation or if an incident happened that affected patient care in the short or longer term. It set out the resources needed during any period of disruption to ensure services to patients and others could continue safely.

The practice manager told us about the close links they had with other GP practices in the area and the support they gave to each other. They also shared information and experiences to help improve the practice and the experience of the patients.

We saw that policies and procedures were accessible to all staff and when asked staff could describe some of the agreed processes. The contact details of other health care services and teams were available for staff to use and at reception we saw how this helped staff members to provide patients with support in a timely way. This included a credit card sized list of contact details of the local mental health services which one staff member had developed.

Equipment

The equipment and facilities available at the practice included signs to help patients with sensory impairments find their way around the premises and disabled toilet facilities with an emergency call bell.

We saw that single use equipment was appropriately used and disposed of and other equipment and services were subject to regular checks and calibration where necessary. Insurance cover was in place to protect against loss or damage of equipment.

There was a subtle change in the floor level in one corridor and a notice warned patients this was a trip hazard. Although risks had been assessed, we found that the notice in itself may not be eye-catching enough to manage these effectively.

Are services effective?

(for example, treatment is effective)

Summary of findings

The Richmond Medical Centre was effective.

The staff had access to research based practice materials such as the National Institute for Health and Care Excellence (NICE) guidance. They had achieved an award following an accredited programme of quality monitoring which showed the practice was open to external scrutiny and willing to learn.

The practice worked collaboratively with other agencies and health care teams including specialist consultants, district nursing services, mental; health teams and local care homes. This showed that the practice supported and engaged with other professionals with the intention of delivering co-ordinated care and treatment.

Our findings

Promoting best practice

There were internal systems and processes in place for staff members to work as a team to manage the quality and development of the service. Most staff members told us that everyone at the practice was involved in learning from developments in healthcare and were committed to putting their knowledge into practice for the benefit of the patient group. The practice manager shared new and updated guidance from the National Institute for Health and Care Excellence (NICE) which provides independent evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, to relevant members of the team. Different staff members acted on behalf of their colleagues to keep up to date with NICE and other relevant guidance and to ensure that the practice implemented this appropriately.

The Royal College of Physicians (RCP) initiative, 'Learning To Make a Difference' was used along with practice guidance to support the practice's quality improvement programme. As part of this, they performed frequent audits of different elements of their practice including; minor surgery, (which showed they did not require registration for this regulated activity) and measurements of prescription practices and its impact. This open approach to learning helped the practice to maintain appropriate safety standards for patients.

We saw that they had been assessed by the Royal College of General Practitioners (RCGP) in 2011 that awarded them the Quality Practice Award (QPA). This assessed and recognised their team approach to the quality of care they provided for their patients and the systems they had in place to help bring about continuous improvement at the practice. The staff spoke proudly about this achievement and the practice manager showed us records which described how they had maintained these standards.

All staff members, including locum staff, (who are temporary staff), were involved in team meetings at the practice. These included regular partner meetings, and administrative and clinical meetings which covered a range of topics to support clinical effectiveness.

Records of patients who were at risk of frequent hospital admissions were kept. These included care plans which were shared with other healthcare professionals such as

Are services effective?

(for example, treatment is effective)

district nurses with the intention of supporting a coordinated approach to patient care. We received feedback from patients who were consulted about the treatment options available to them. One patient told us their GP listened to their problem and took their thoughts on drugs into account when deciding the best course of treatment to recommend.

Management, monitoring and improving outcomes for people

The practice manager kept a close overview of the business side of the practice. They made sure that everything ran smoothly; they developed, monitored and audited patient services and that they were meeting national targets.

Changes had been made in certain Quality and Outcomes Framework (QOF) standards meaning the practice was no longer required to check some patient symptoms under the scheme. QOF is a voluntary incentive scheme for GP practices in the UK and provides performance management information about how they care for patients. We saw that these particular aspects of patient care were still being monitored by the practice using their own internal clinical review systems. This showed that the practice was committed to maintaining a comprehensive focus on the clinical assessment of patient needs.

A range of patient information was kept on the computer system some of which identified patients who may have been at risk or whose individual circumstances may have meant they required regular review or particular attention from their GP. The practice had identified that one such group, who were higher than average users of local accident and emergency departments may require a greater level of monitoring and care. They had also notified patients over the age of 75 years that they would have a named doctor to oversee their care and treatment. Arrangements had been put in place to ensure that this would not have an impact on the GP the patient could choose to see.

From records and our discussions with staff members we saw that clinical evaluations also took place in response to local or national areas of concern such as the number of physiotherapy referrals made by the practice and the level of access to cervical screening. The latter had been identified as a more wide spread concern in primary health nationally. The learning from these reviews was shared amongst the staff team as appropriate. This helped the practice to demonstrate where the practice was clinically and cost effective.

The regular analysis of records helped to identify those patients who were eligible for periodic health and screening tests such as cervical screening. Systems were in place to remind patients to attend for tests when necessary. Processes were also in place to oversee patients who were at risk of hospital admission, who needed treatment or medication reviews or scheduled vaccinations. Their organised approach to this, reduced risks to patients with long term conditions by ensuring they received regular health monitoring and reviews.

The data we saw prior to our inspection showed that the practice had a higher number of older patients registered at the practice. We spoke with staff members of five local care homes and they all reported that the residents who were registered at Richmond Medical Centre were highly satisfied with standards of care and the services provided. The response from all of the care homes was that they did not have any concerns about the practice. There were no problems accessing appointments and the GPs regularly visited their patients. They all thought the practice staff were helpful and considerate and for many, the Richmond Medical Centre was their surgery of choice.

Staffing

The needs of patients who used the service were met by the number and skill mix of the staff team employed. In addition to the practice manager there were 13 administrative staff, one of whom was also trained to as a healthcare assistant. There was one other healthcare assistant, three practice nurses and six GPs. Domestic staff ensured the premises met the required standards of cleanliness.

All new staff went through an induction process which was specific to their role. A locum induction pack had been developed and the locum said they were well supported and felt part of the staff team. Newer staff confirmed that they had a good induction to the practice and had some protected time to familiarise themselves with policies and procedures and to understand the routines of the practice.

The annual appraisal system included an individual assessment of each staff members learning needs. The

Are services effective?

(for example, treatment is effective)

practice manager described the importance they placed on recruiting staff who shared their values in addition to having the potential to learn and develop the skills needed to be an effective member of the team.

Some administrative staff developed skills to become healthcare assistants (HCA) providing care to patients. They were mentored by a member of the clinical staff team during their training who signed them off to work independently once they had achieved an acceptable standard of practice. There was no recording process to confirm that the HCA's level of competence had been reached before they were 'signed off'. The staff confirmed there were periodic checks made to make sure HCA's continued to practice at the agreed standard but records were not kept of this. It may be helpful for the practice to keep a record of these checks and the outcome.

We saw the arrangements in place to support the revalidation of clinical staff. Revalidation is the process doctors are required to use to demonstrate that they are up to date and fit to practice. A similar system is required of registered nurses and other healthcare professionals. To support the revalidation process, clinical staff received feedback from their colleagues. This was called 360° feedback and was undertaken as part of their annual appraisal. The clinical staff told us that the practice invested in their staff by giving them training and professional development opportunities and the records we saw supported this.

There were effective systems in place support staff and to manage concerns about the practice or the behaviours of its staff. All of the staff spoken with described an open, positive and inclusive approach to the management of the practice. Without exception, the staff felt well supported in their roles. We saw one example where the practice had used their management procedures to address worries related to staff practice.

Working with other services

The practice worked well with partners including local care homes, district nursing services and others.

Arrangements were in place for the shared care of patients who used the service. Shared care is where the prescribing responsibility for treatments which were initiated in hospital are transferred to the GP. The hospital consultant retains the clinical responsibility for the patient and the GP acts on their advice. Shared care arrangements may be useful to support the discharge of patients back into the community and help provide continuity of care.

Patients under the care of the midwife could contact them directly to make appointments for antenatal and postnatal appointments which were hosted at the Richmond Medical Centre. They worked alongside health visitors and regularly liaised with the practice team. District nurses supported people who were receiving end of life care using the Gold Standards Framework. We spoke with three external healthcare professionals who had links with the practice. They all thought they had a positive working relationship with all of the staff at the practice and effective communication systems, particularly about new referrals. The practice hosted a monthly primary care meeting which promoted closer partnership working and joined up care for patients.

The practice received messages from out-of-hours services, and accident and emergency departments to share information about patients who had accessed these services. This helped to ensure that the practice could provide follow up care and treatment if necessary. Work was being undertaken to identify patients who used these services regularly to understand why this might be and to reduce this if possible. Work was also underway alongside the local Urgent Care Team to identify patients who had received unplanned admissions to hospital to look at ways of reducing the necessity for this.

The practice worked with other healthcare services such as the midwifery, district nursing and community mental health teams with the intention of providing a coordinated and safe approach to patient care. Safeguards were in place to protect patient confidentiality. When necessary, information was appropriately shared between teams about patients with complex needs or where there were concerns about their health and well-being.

Health, promotion and prevention

Systems and arrangements were in place to support the prevention and early detection of ill health among the patient population. A range of health tests were carried out as part of the new patient health check and health promotion advice was also shared with patients at this time. This also provided an opportunity to identify any health risks so that agreements could be made with patients to manage these risks. Existing patients, under the

Are services effective?

(for example, treatment is effective)

age of 75 years and who had not had a consultation in three years could request an appointment for a health check. Patients over the age of 75 could have a health check every year. NHS checks for patients over the age of 45 were offered health checks to calculate cholesterol levels and the future risk of heart attack and stroke amongst other tests.

The practice encouraged those patients who had caring responsibilities to inform the practice so that they could receive a carer's assessment. The intention was to enable carer's access to support and other relevant information and guidance.

The Clinical Commissioning Group (CCG) was promoting an initiative called Making Every Contact Count (MECC) where GPs and practice staff encouraged patients to make healthier lifestyle choices to improve their health and wellbeing. CCGs are groups of GPs responsible for designing local health services in England. The Richmond Medical Practice was assisting this scheme by displaying relevant health promotion information and leaflets.

The practice manager used the QOF to organise the reviews of patients with long term conditions. These included patients with Chronic Obstructive Pulmonary Disease (COPD) heart disease and diabetes who were reviewed at least annually.

We found there were effective arrangements in place to manage and monitor the childhood vaccination programme. The practice nurse regularly liaised with health visitors who then visited children at home if necessary.

A range of tests were offered at the practice including spirometry (which is a breathing test), hearing tests and blood pressure monitoring. NHS checks for patients over the age of 45 were offered which tested cholesterol levels and calculated the future risk of heart attack and stroke amongst other tests.

Are services caring?

Summary of findings

The Richmond Medical Centre was caring.

The feedback we received from all patients was mainly positive. They were supported by a friendly and caring staff team and received dignified care.

The clinical team gave examples of how they considered patients views about the way the practice was run and with regard to their individual health needs and treatments. Those patients we asked confirmed this was the case. They said they were given enough consultation time with the GP or practice nurses and they were listened to. This showed that patients received information about their condition and where possible had options about their care and treatment.

Our findings

Respect, dignity, compassion and empathy

Senior staff at the practice promoted an environment of openness and respect where patients and staff felt valued and had their opinions taken into account. We spoke with 13 patients all of whom had positive comments to make about their experience of the practice. They found the practice to be friendly and helpful and they felt they received good medical attention from their GP and from the practice nurses.

The results of the patient survey for 2014 noted improvements in the attitude of the reception staff. We observed that the staff members at reception knew how to treat patients with dignity and respect. We heard and observed staff members consistently greeting patients and others in a polite and helpful way. They addressed patients using their preferred name and sought their permission before discussing private personal information with them or other members of the practice team.

The reception was open plan making it difficult for staff to fully protect patient confidentiality. Patients confirmed that the layout of the reception area meant it was not a confidential space. The design of the new build surgery which was panned to be completed in 2015 would address this problem. In the meantime, the staff members used various methods to overcome this issue as far as possible including speaking in a lower tone; being careful not to repeat patients' names and addresses out loud and by not discussing patient issues with other staff in this area. There was a private area for staff to hold telephone conversations or meet with patients in private if necessary. We saw that medical consultations and examinations took place in private.

Computer screens which showed confidential patient data faced inwards so that this sensitive information could not be seen by patients arriving at the surgery. There was a large filing stand of paper based patient records which was behind the reception desk but which patients passed close by on their way to consultation rooms. We discussed the lack of security of these records with the practice manager and the practice arranged to have them removed to a secure space.

We spoke with patients and representatives of the 300 strong Patient Reference Group (PRG) which is a patient led

Are services caring?

group that works with the practice to improve services, all of whom were satisfied with the way they were treated by the practice staff and the care and compassion they were shown. Patients, who were the relative and / or carer of other patients who had died, were visited by a GP to offer their condolences and find out if they needed any particular help and support. One patient told us that they worked with people with "special needs", some of whom used the surgery. They confirmed that there were no problems in getting appointments and their clients were treated well by the receptionists and doctors. This patient recalled when one doctor, at a consultation, asked the client if it was okay with them if they spoke with their carer. This showed respect for patients who used services and who had more complex needs.

Involvement in decisions and consent

The GPs supported patients to understand their care and treatment options including the risks and benefits and providing information to enable them to be involved in making decisions.

The feedback we received from patients suggested that they were routinely involved in decisions about their care and treatment. Patients said the GP discussed the care and treatment options available to them. Patients said their views were listened to and taken into account before a decision was made about their treatment. They told us they spent enough time with their GP to ask questions and they had confidence in the ability of the GP plan their care effectively. Patients told us that their GP consultations were thorough and considered. They thought the GP listened to them and they were consulted about their treatment options. We saw leaflets providing information about different medical conditions and treatment options were available for patients.

Patients told us they had a choice about which GP they could see and about where their assessments and treatment could take place if this was being provided by other healthcare services. At reception we heard the staff offering advice to patients who attended the practice or on the telephone. Some patients needed advice on what they should do to prepare for health tests. The reception staff gave clear guidance, some of which was in writing to the patients. They asked if they understood and if they had any questions.

We saw that home visits were made to patients with a learning disability if the patients found it stressful to attend the surgery in person. One staff member told us that some patients were more relaxed and responded better if the GP visited them in their own home. The staff members we asked knew that some people may lack the capacity to make some decisions and may need additional support with this. The practice had guidance for staff on how to communicate with a person who may lack capacity or have particular communication needs.

There were arrangements in place to share information with other services such as the out of hours service about the decisions made in relation to end of life care. This included decisions about resuscitation.

We found that translation services were available to support patients whose first language was not English. The staff were aware of the possible conflict of interest and risk to patients if they relied on children or other family members to translate for patients and this was avoided wherever possible. Information about the practice was available in different languages.

The PRG helped to facilitate the annual survey and analysed the results after consulting with patients. They were also operating the, Friends and Family' test which is where patients say if they would recommend the practice to those close to them and if not why.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The Richmond Medical Centre was responsive to people's needs. Services were planned and delivered in partnership with other organisations to meet the diverse needs of the local population.

Patients told us their urgent needs were met in a timely way by the practice but a majority also said that the appointment booking system could present delays and be frustrating. The practice had responded to this by having three different ways to book an appointment.

There was an open culture at the practice and a clear complaints process and effective patient feedback system in place. This showed that the practice encouraged the involvement of patients in decisions about the planning and organisation of their services. They learned from the experience of patients and adapted their practice with the intention of improving the quality of care.

Our findings

Responding to and meeting people's needs

Richmond medical Centre worked with the Clinical Commissioning Group (CCG) and other GP practices in the area to understand the needs of the local patient population and to organise services to meet those needs. CCGs are groups of GPs that are responsible for designing local health services in England.

The practice had information available about their local population including age, levels of deprivation and the prevalence of disease. This helped them to work collectively to plan services to meet patient's needs.

Representatives of the practice regularly attended meetings with the CCG where priorities of care were discussed and organised. We saw that the practice was supporting a range of initiatives designed to reduce health inequalities and support patients' healthcare needs in the community. We saw that the practice was already working alongside other local health and social care teams toward locally agreed goals, such as reducing the number of non-elective admissions to hospital by improving the coordination of care to older people in the community.

The Richmond Medical Centre had either put into practice or was working toward the implementation of several interventions in line with the CCG's objectives for 2014 and 2015. They had introduced the Friends and Family test ahead of schedule and were identifying those patients who were regular users of out of hours and accident and emergency services.

We saw other examples of how the practice was working to meet the needs of different patient groups in their area. They worked alongside district nursing teams to provide a well-coordinated approach to end of life care. One patient told us about their experience of the support their family received from the practice when a close relative was approaching the end of their life. The practice supported young adults using the 'C' card scheme by offering confidential advice aimed at helping young people make safe choices about their sexual health. Consideration was given to ways in which annual health checks of patients with a learning disability could meet their specific individual needs.

Patient safety was routinely discussed at team meetings and patient records were subject to audits to identify and

Are services responsive to people's needs?

(for example, to feedback?)

address risks such as prescribing issues and adequacy of services, such as cervical smear coverage and other trends. This helped the practice to understand the standard of services they provided for their local population and make adjustments if necessary.

The Patient Reference Group (PRG) which is a patient led group that works with the practice to improve services, surveyed patients asking them to describe in no more than 20 words what the practice did well and what they needed to improve. They used this information to identify ways of improving the services provided and to generate an action plan with timescales. Representatives of the PRG told us their work was taken seriously and was well supported by the practice.

The practice was located in single storey accommodation which had been extended with the use of temporary buildings to manage the increase in patient demand and services. There was level access into the main building with automatic doors and ramped access to different parts of the building. A wheelchair was available for patients to use if required and adjustable examination couches were also in place. There was also a loop system (which is a type of communication aid) to support patients with hearing loss.

Access to the service

We received mixed feedback on the availability of appointments and this was the most common concern expressed by patients either directly to us or via the patient survey which was undertaken by the PRG. We found that patients had three options open to them to make their appointment. They could make their appointment in person, by telephone or on line. All of the patients we spoke with said they could access a same day appointment in urgent circumstances if they needed to. We received mixed feedback about the telephone triage system. This is where patients who called the practice before 11 am to request a same day appointment received a telephone consultation before a decision was made as to whether a face to face consultation was needed. Although some patients objected to this option the results of the patient survey showed that the majority of patients (116 out of 131) felt this system allowed them to discuss their issue and receive the treatment they needed.

The practice had its own website which provided useful information about their opening times and the services they provided and advised patients what to do in the event of an emergency situation. All of the information provided was available for translation into a wide range of languages including those most commonly spoken in the CCG area.

There was reserved parking for patients with a disability.

Concerns and complaints

The practice had a robust and effective complaints procedure which was displayed in the reception area alongside information about NHS advocacy services. A brief summary of the complaints procedure was available on the practice website. The PRG said that the majority of the complaints they received from patients were about the quality of the building and not being able to see their GP of choice. Those patients we asked told us they knew how to complain if necessary but said they had never had cause to do so.

We saw that the practice took complaints seriously and acted promptly on information of concern they received. They managed formal and informal complaints in an open and transparent way. The practice manager kept a separate log of information complaints which were quickly resolved. These were reviewed annually alongside formal written complaints when learning points and actions were agreed.

The practices learning points, following investigations into complaints and other events had made recommendations about staff practice. These included how patients were helped to understand the routines of the practice such as the appointment and triage systems. The staff we spoke with were aware of these issues and what they needed to do to ensure the problems did not happen again.

The staff knew about the practice's whistle blowing policy and procedure and we saw one example of when this was used. The concerns made had been investigated and managed effectively in the best interests of patients using the service. This meant that staff had access to clear procedures from which they could voice their concerns and felt safe and supported in doing so.

Are services well-led?

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

Summary of findings

The Richmond Medical Centre was well-led. The leadership at the practice was open and transparent and willing to take advice to improve. They were supportive of staff and encouraged their professional development.

There were effective systems in place to monitor the quality of the services provided. There were clear structures and lines of accountability in place to manage and support the staff team. There were strong clinical governance systems in place.

Staff members said they felt valued and proud to work at the practice.

Our findings

Leadership and culture

All of the staff we spoke with said they enjoyed working at the practice. They commented that they felt supported and valued in their roles and some said they wouldn't want to work anywhere else.

The staff described an open approach to addressing adverse events, incidents and errors which helped to promote an open and fair culture of safety at the practice. This supported staff to be able to raise concerns confidently and we saw records of when this had happened.

Most of the feedback we received from patients commented that the staff at the practice was positive and acknowledged the kindness of the staff and their positive and respectful approach. The staff could meet with the practice manager whenever they wished. They said they addressed any concerns soon after the event which helped them to sort out any problems in a timely way.

Governance arrangements

We received positive feedback about the organisation and management of the practice and the availability of policies and procedures and systems to measure their successes and areas for improvement.

There were clearly defined roles and responsibilities held by different members of staff. They knew who they were accountable to and what lead roles each member of staff had responsibility for. A list was produced of the various link roles which enabled the practice to keep on top of developments in these areas. These included responsibility for infection control; fire safety and clinical governance among others.

The registered manager at the practice was also the nominated Caldicott Guardian. This is the name given to the staff member responsible for information sharing and confidentiality. We saw one record concerning a breach of confidentiality. This was appropriately addressed using a significant event analysis (SEA), which enables practices to learn from patient safety incidents and identify the strengths and weaknesses in the care and services they provide. We spoke with staff and found this learning had been embedded into practice.

Are services well-led?

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

Records were kept of regular practice meetings including team meetings and clinical meetings to discuss practice issues and agree the most appropriate course of action to take.

Systems to monitor and improve quality and improvement

The practice regularly engaged with their local Clinical Commissioning Group (CCG) which is a group of GPs that are responsible for designing local health services in England. At these times and on other occasions the practice had participated in meetings with other GP services to share experiences and good practice.

Regular audits, against national standards were carried out as part of the clinical governance programme to help the practice manager and the clinical team evaluate services and improve quality where necessary. The audits which had been undertaken included: the adequacy of cervical cancer testing coverage; the number and reasons for physiotherapy referrals and high users of accident and emergency and out-of-hours services.

Patient experience and involvement

The practice had processes in place to engage with patients who used the service and to respond to their feedback.

During the inspection we met the Chairperson for the Patient Representation Group (PRG). The PRG is a patient led group that works with the practice to improve services. All registered patients were invited to become a member of the PRG although there was a smaller group of 12 members who had delegated decision making responsibilities. There were 300 members of the PRG and they described themselves as a, "critical friend" of the Richmond Medical Centre. They met every two months and utilised the skills of their membership to create 'sub groups' which explored specific topics of importance to the practice and its patients.

Part of the PRG's responsibility was to obtain feedback from patients on their experience of the practice. The 2014 survey had taken place and the results had been presented to the practice for consideration. In this survey the PRG had left a blank space on questionnaires so that patients could record their feedback about any aspect of their experience of the practice.

Staff engagement and involvement

Most staff said they enjoyed working at the practice and they felt that their contribution was valued by the wider staff team. We received consistent messages from them that management invested in their staff which encouraged them to work well together with a shared ethos and vision for the practice.

Learning and improvement

We were told that it was the practice staff that identified and led on team development issues. They had identified the learning needs of individuals and of the team as a whole. There was a set of training courses that all staff attended and then individual assessments were done during appraisals to plan for staff individual professional development needs. One staff member had been supported to access a higher level course in a health related field.

The practice staff held lead roles at the practice some of which were aligned to their individual areas of knowledge and expertise.

Identification and management of risk

The practice monitored quality and safety issues and these were discussed at team meetings including clinical meetings. All of the staff we spoke with were aware of the incident reporting processes and they understood their obligation to report any concerns they had.

A risk assessment had been undertaken on the building to highlight areas of concern and agree any actions needed to reduce the risk. Signs had been put up to alert patients and others who used the service to the risks. We raised a concern with the practice that this may not have been sufficient to warn people of a trip hazard in one corridor. The practice immediately agreed to apply a hazard strip to the floor. We are unable to confirm if this action has been completed.