Topsham Surgery

Quality Report

Holman Way
Topsham
EX3 0EN
Tel: 01392 874646
Website: www.topshamsurgery.gpsurgery.net/

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Topsham Surgery on 14 July 2015. The practice is rated as good. Specifically, it was good for providing safe, effective, caring, responsive and well led services. It was good for providing services for all the population groups, older people, children and young people, people with long term conditions, people experiencing poor mental health, people in vulnerable circumstances and people who are working age or recently retired.

Our key findings were as follows:

- Outcomes for patients were positive, consistent and met expectations. Patients confirmed they were seen or spoken with on the same day if they had an urgent need. GPs kept individual lists so all patients had a named GP.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Reliable systems were in place to maintain safety throughout the practice.
- There was up to date IT support to enable staff to manage patient records well and provide them with the latest NICE guidance.
- Treatment rooms and public areas were clean and there were systems in place to ensure hygienic conditions and equipment.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. This practice was safe and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Equipment was checked and tested required. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data showed the practice had systems in place to make sure the practice was effectively run.

The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national current practice guidance. The practice worked closely with other services and strived to achieve the best outcome for patients.

Supporting data showed staff employed at the practice had received appropriate support, training and appraisals had been undertaken for all clinical staff. GP partner appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The needs of the local population were reviewed and the practice engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make

Summary of findings

an appointment with a named GP and that there was continuity of care. The practice provided a flexible appointment system which involved a duty GP, to ensure all patients who needed to be seen the same day were accommodated.

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the vision of the organisation and their responsibilities in relation to this. The strategy to deliver the vision was regularly reviewed and discussed with staff. There was a leadership structure in place. The practice manager played a central role in the coordination and running of the practice.

Staff felt supported by management. There was a stable staff group and high level of job satisfaction and support for nursing and clerical staff. The practice had a number of systems, policies and procedures to monitor risk, clinical effectiveness and governance and to share learning from any events. The practice valued and proactively sought feedback from patients and staff and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions and had attended staff meetings and events.

Staff said they felt well supported and enjoyed their work. There was a stable staff group with most staff having worked at the practice for many years.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice had a register of all patients over the age of 75 and these patients had a named GP. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example dementia, shingles vaccinations and seasonal flu vaccinations.

The care for patients at the end of life was in line with the Gold Standard Framework. This means they work, as part of a multidisciplinary team and with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes.

The practice was responsive to the needs of older people. GPs, nurses and health care assistants provided home visits and rapid access appointments for those with enhanced needs. We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over and for those who were vulnerable.

The practice had responded to the high numbers of older patients requiring leg ulcer treatment in the area by providing a leg ulcer clinic on a weekly basis. Staff included a leg ulcer specialist nurse and a health care assistant trained in leg ulcer dressing. Between April – June 2015 the clinic received seven patients who required compression bandaging. The practice leg ulcer clinic had completely healed four of these seven. The remaining three had made significant improvement and continued to attend the clinic.

People with long term conditions

Good

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

The practice had clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encourage self-care for these patients.

The practice ran seven different chronic disease clinics. This included weekly diabetic clinics to treat and support patients with diabetes which included education for patients to learn how to

manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style. If a patient had more than one chronic disease they were able to attend for one extended appointment in order to treat their full range of needs.

The practice worked closely with the community matrons for patients who had acute conditions to prevent hospital admissions. Patients who were on the unplanned admissions register were contacted following admissions to identify any changes to care and treatment required and reviews of care were discussed at practice meetings.

Clear alerts were placed on the appointment system highlighting vulnerable patients to ensure reception staff acted in a timely manner and allocated same day appointments or home visits.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up vulnerable families who were at risk.

Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Staff dealing with young people under 16 years of age without a parent present were clear of their responsibilities to assess Gillick competency. Sexual health, contraception advice and treatment were available to young people including chlamydia screening. The practice provided two late evening cervical smear clinics a month.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Immunisation rates were high for all standard childhood immunisations.

All of the staff were very responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Staff were knowledgeable about child protection and proactive in raising concerns with the safeguarding lead to follow up on any identified. A GP took the lead for safeguarding with the local authority and other professionals to safeguard children and families.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The staff were proactive in calling patients into the practice for health checks. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. This gave the practice the opportunity to assess the risk of serious conditions on patients which attend. The practice also offered age appropriate screening tests including prostate and cholesterol testing.

Patients who received repeat medications were able to collect their prescription at a place of their choice. The staff often posted the prescription to a pharmacy of the patient's choice, which may be convenient to their work place. Patients had access to an online repeat prescription service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had offered annual health checks to 61 registered patients with learning disabilities and 26 of these patients had received a health check since April 2015. The remaining 25 were planned to take place between July to March 2016. The practice offered longer appointments for people with learning disabilities and recognised their individual needs.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out-of-hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All people experiencing poor mental health had received an annual physical

Summary of findings

health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and in house wellbeing services were provided on site. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

On the day of our inspection we reviewed 18 comment cards, which had been completed in a two week period before the inspection date. All of the comments we received were positive about the experience of being a patient registered at the practice. There was a recurrent theme of patients saying that they were treated with support and care.

We also spoke with 30 patients and their views aligned with the comments in the cards we received. Patients gave us positive examples of treatment they received and support offered by practice staff. All said they were treated with dignity, respect and kindness by staff. Results from the most recent GP national patient survey stated that 95% of 130 respondents describe their overall experience of the practice as good. Also 90% of patients would recommend this GP practice to someone new to the area. This was higher than the CCG average of 86%.

Patients said the nurses and GPs were very caring and they had received an excellent service. One patient said they had received first class treatment at all times including when they were really unwell and needed advice and an emergency appointment. Patients said their GP always listened to what they had to say. Patients said their GP had given very good in-depth explanations when they needed further treatment. Others said the GP got the right information for them, listened to them and their questions had been answered.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Patients said they felt the practice offered a good service and both clinical and administrative staff were helpful and caring. They said staff treated them with dignity and respect.

Areas for improvement

Topsham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. It included a GP specialist adviser, a practice nurse specialist adviser and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Topsham Surgery

Topsham Surgery was inspected on 14 July 2015. This was a comprehensive inspection.

The practice is situated in the coastal town of Topsham. The practice provides a primary medical service to approximately 9,788 patients. The practice is a training practice for doctors who are training to become GPs.

There is a team of nine GP partners (four female and five male). Partners hold managerial and financial responsibility for running the business. The team were supported by a practice manager, finance manager, four female practice nurses, three female health care assistant and a female phlebotomist. The clinical team were supported by additional reception, secretarial and administration staff.

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

The practice is open from Monday to Friday, between the hours of 8am to 6pm. Appointments were available to be booked up to six weeks in advance and take place between 8.30am to 6.30pm. Patients told us they felt the appointment system was good. Extended hours were offered by the GPs and nurses on a weekly rota basis. Evening appointments were available from Monday to Thursday from 6.30pm until 7.45pm.

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

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service. The practice provided services by way of an NHS personal services contract.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 July 2015.

During our visit we spoke with a range of staff including five GPs, two practice nurses, the practice manager and members of reception and clerical staff. We spoke with 30 patients who used the service. We reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts.

The number of incidents reported in the last 12 months was low but where they had occurred, investigations, outcomes and actions were clearly documented. The staff we spoke with were aware of their responsibilities to raise concerns and were able to describe the procedure for reporting incidents and near misses.

Staff were able to describe a recent incident involving a patient who attended an appointment and received an unnecessary vaccination. Improvements arising had been implemented and the practice had apologised to the patient for the incident. There had been shared learning with the nursing team and the incident had been discussed at a significant event meeting in February 2015.

Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe. We reviewed minutes of meetings where incidents and complaints were discussed during the last 12 months and reviewed incident reports which had been collated for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events and incidents were reported on a standardised form which included a description of the incident, what went well in handling the incident, what could have been done

differently and what could be learned from the incident to prevent a reoccurrence. Staff including receptionists and administrators were aware of the process to follow and send completed incident forms via email to the management team. There were written records of significant events that had occurred during the last year and we were able to review these.

An example of a significant event included a patient who was requested via email to book a routine appointment within two weeks. The email had been sent to an incorrect email address. A member of staff checked the booked appointments log and found that the appointment hadn't been booked. The staff member then booked the appointment. Processes had been improved to prevent this happening again. Checklists had been put in place which ensured that the two week wait log for a booked appointment was now checked on a weekly basis.

National patient safety alerts were disseminated by email and at the clinical meetings to staff. Staff we spoke with told us that they had received information about alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were safeguarding policies in place for both children and vulnerable adults which included contact details for local safeguarding and social care teams. Flowcharts detailing the procedure for escalating safeguarding concerns were posted in consultation rooms for quick reference to ensure staff reported any concerns promptly.

We saw training records which showed that all staff had received relevant role specific training in child protection. All administrative staff were trained to level one and all clinical staff were trained to level three in accordance with national guidance. Staff had also received training in the protection of vulnerable adults. The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. The safeguarding lead had been trained in safeguarding adults and also level three child protection to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. We asked administrative staff about their most recent training. Staff we spoke with were able to describe signs of abuse in older people, vulnerable adults and children. Staff were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

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

Good

Are services safe?

The practice had a chaperone policy and signs were visible on the reception desk notice board and in the consultation rooms offering the chaperone service. We were told that clinical staff did this. Chaperoning was done by those with a DBS (Disclosure and Barring Service) check. Chaperone staff had been appropriately trained.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a breach of these temperatures. The fridge temperature was checked and documented once a day and we saw appropriate temperature range had been maintained. The practice nurses were responsible for ensuring medicines were in stock and within their expiry dates. All the medicines we checked were within their expiry dates. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

We found two controlled drug items were past their expiry date. They were securely stored in line with the latest guidance. The practice was aware of these expired medicines and had contacted NHS England Optimising Prescribing team to log them and requested their "destroy instructions" which would set out the correct method for their disposal.

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 that generate prescriptions were trained and 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.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We reviewed cleaning schedules and records detailing the frequency and areas of cleaning undertaken. These schedules were detailed on an individual room basis and took into account the purpose of how each room was used. All of the patients we spoke with said they always found the practice to be clean and tidy and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits in the last year and that any improvements identified for action were completed on time. An infection control audit had been completed in March 2015. The audit had identified that any spillages should be dealt with by trained nurses and not by administration staff. This was immediately shared with all staff responsible and further checks undertaken to ensure it continued.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the practice had a clinical waste management protocol in place and waste was segregated, stored safely and disposed of by a professional waste company. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff informed us that all PPE and probes used in examinations were single use to minimise cross-infection risks.

The practice had a contract with an external agency for daily safe removal and disposal of sharps waste.

The practice had a risk assessment in place for Legionella (a germ found in the environment which can contaminate water systems in buildings). Checks were carried out on a weekly basis.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly for patient use and we saw equipment

maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was September 2014. A schedule of testing was in place. Calibration of medical equipment was undertaken by an external contractor annually.

Staffing and recruitment

Records showed that there was a low turnover of staff at the practice. We looked at three staff records, all of which contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring

Service (DBS) (clinical staff only). All of the records contained photographic identification. Administration staff had a written risk assessment in place stating why a DBS check was not necessary for their role.

Original checks had been completed, which showed that the performers list had been checked when GPs and locums were recruited. Copies of medical defence insurance were seen in files, which were valid for the current year. The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only nurses or healthcare assistants had this additional duty and a DBS had been obtained for all of them.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed meet patients' needs. Nurses had completed several advanced nursing diplomas. These included diabetes management, contraception, sexual health promotion and mental health.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which had been reviewed in March 2015. Health and safety information was displayed for staff to see and the practice had a nominated health and safety representative. We saw evidence of health and safety risk assessments where identified risks were logged in a risk assessment table. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. For example, if the baby changing mat was incorrectly stored there was a risk of it falling and hitting someone. A notice had been placed on the wall to enable it to be put back correctly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in September 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED – a device used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Equipment was available to help adults and children who were having difficulty breathing.

Every staff member with access to a computer screen could request immediate assistance. This function was used if a patient collapsed or who otherwise became acutely unwell. By requesting immediate assistance an alert goes to all logged-on users of the computer system.

Risks to safety from service developments, anticipated changes in demand and disruption were being assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations. A business continuity plan was in place, last reviewed May 2015.

The business continuity plan covered the range of anticipated emergencies, assessed their potential impact and assigned responsibility to staff for alerting others and preventing escalation. This covered breakdown of systems including computers, adverse weather including flooding. Arrangements were in place to arrival of an infected or contaminated patient as well as a strategy to act in the

Good

Are services safe?

event of a pandemic perhaps in collaboration with other neighbouring practices and/or the CCG and Public Health England. Clear instructions for staff had been prepared and useful contact details listed.

The practice had a fire safety policy, a fire safety log book and designated members of staff had nominated duties. Weekly fire alarm checks were undertaken and fire drills had been practiced regularly to ensure patients and staff could be evacuated in the event of a fire. An external agency provided annual fire protection equipment servicing and a fire risk assessment was in place dated March 2015. Outstanding actions had been implemented. For example, electrical installations had been tested in June 2015. A fire drill took place in June 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines.

The GPs told us they led in specialist areas such as women's health, rheumatology and joint injections, psychological aspects of medicine and travel medicine. Practice nurses led clinics for specific conditions such as asthma, chronic obstructive pulmonary disorder and diabetes which allowed the GPs to focus on patients within their specialist areas. Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance.

We saw practice performance data for patients was used for effective needs assessment. For example, 81% of 2,244 patients who required it had received cervical screening. This was higher than the QOF target of 45-80%. Of the 35 patients aged 14-19 years who had asthma, 100% had been reviewed. This was higher than the QOF target of 80%.

The practice used computerised tools for information regarding patients who had experienced an unplanned admission to hospital and this would be forwarded by the administration team to the patient's named GP.

The practice referred patients to secondary care and other community care services appropriately. Data showed that the practice was performing in line with CCG standards on referral rates for all conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. Patients we spoke to told us that they felt listened to in decision-making about their care.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. The practice managed the care of patients over the age of 75, patients with mental health conditions and patients receiving integrated and palliative care by allocating them a named GP.

These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us 15 clinical audits that had been undertaken in the past year. All of these audits had dates factored in to repeat the process and complete a full cycle. The practice showed us an example where a change had occurred resulting from an audit. We saw that an audit regarding the management of asthma looked at patients who had used six or more asthma relieving inhalers and the underlying reasons for this. Service improvements from the audit included an adjustment or patient's prescription where appropriate and lifestyle advice. Further audits were carried out on a monthly basis to identify patients at risk of asthma exacerbations. This enabled clinical staff to provide these patients with comprehensive plans to manage their asthma more successfully.

In October 2014 GPs an audit had been undertaken to review patients prescribed vitamin B compounds. The prescription of vitamin B was no longer recommended for use in patients with a history of alcohol excess, and alternatives were suggested. The audit had found six patients where alternative treatments would be more effective. These had been implemented.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 97% of 67 patients with dementia had an annual face to face review. QOF target was 70%.

An audit was conducted in April 2015 of patients using different kinds of insulin pen needles to treat their condition. This had resulted in 14 patients switching to more effective treatment methods. The audit was planned to be repeated in April 2016.

The team was making use of audits, clinical supervision and staff meetings to assess the performance of clinical

Good

Are services effective?

(for example, treatment is effective)

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

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as quarterly multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

Effective staffing

The practice had an experienced team of staff that included medical, nursing, managerial and administrative staff. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England. The practice held long well established links with local medical schools and had provided training for student doctors and doctors continuing in their education. Medical students in year one to five of their training to become doctors were placed at the practice. Three current partners were formerly GP registrars at the practice.

A supportive and positive culture within staff was evident throughout our inspection. All clinical staff undertook annual appraisals which identified learning needs and the practice was proactive in providing training in the areas identified. Nursing staff at the practice had defined duties and were able to demonstrate they were trained to fulfil these duties. Those with extended roles for example, triage had extended training in physical assessment.

Working with colleagues and other services

The practice had effective working arrangements with a range of other services such as hospital consultants and local and voluntary groups. A patient representation group called the Estuary League of Friends worked closely with the practice in social activities for patients, patient transport and befriending.

The practice was involved in various multidisciplinary meetings involving palliative care nurses, health visitors, social workers, and community nurses to discuss vulnerable patients at risk, those with complex health needs, and how to reduce the number of patients needing hospital admission. The lead GP for safeguarding children attended multidisciplinary meetings with the school nurse, health visitors and midwives to discuss patients on the child protection register and other vulnerable children. A continence adviser held a clinic at the practice once a month. There was a weekly depression and anxiety support service. Working with these other services enabled the practice to have a multidisciplinary approach which ensured each patient received the appropriate level of care.

The practice worked with other service providers to meet patients' needs and manage complex cases. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Devon single point of access scheme. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

Good

Are services effective?

(for example, treatment is effective)

For the most vulnerable 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Regular meetings were held throughout the practice. These included all-staff meetings, clinical meetings and partner meetings. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA) and the Children's and Families Act 2014 and their duties in fulfilling it. Formal training in the Mental Capacity Act 2005 had been undertaken by GPs, nurses and senior administrative staff. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs demonstrated an understanding of both Gillick and Fraser guidelines (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). Patients with a learning disability and those with dementia were supported to make treatment decisions through the use of care plans, which they were involved in agreeing.

Health promotion and prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. It was practice policy to offer all new patients registering with the practice a health check with a health care assistant. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with depression and 36 of 38 patients had received an annual physical health check. This was 95% which was higher than the QOF target of 80%.

The practice referred patients to a smoking cessation support clinic to assist patients who were recorded as smokers. The practice had one of the highest referral quit rates in the local CCG. Of every 1000 patients who smoked referred from Topsham Surgery, 2.25 patients had quit smoking. This was higher than the local CCG average quit rate of two patients.

The practice's performance for reviewing patients with hypertension was 89%, which was better than the national average of 80%. There was a policy to offer telephone reminders for patients who did not attend for hypertension checks and the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with, or above average for the CCG. There was a clear policy for following up non-attenders by the named practice nurse.

The practice was a nominated yellow fever travel vaccination centre.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from information from the national GP patient survey 2015. We spoke to 30 patients during our inspection and we received 18 Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed a high level of satisfaction of patients with their

GP practice. The results of the GP patient satisfaction survey showed that of the 130 responses received, 96% of patients described their experience at the practice as good which was higher than the local CCG average of 90%. We received 18 comment cards and all of these stated that the service was good, very good or excellent.

The patient representation group run by volunteers provided free transport with their own cars for those patients who did not have the ability or means to use public transport. It enabled vulnerable patients to visit the practice for their appointments.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP Patient

survey showed 96% of practice respondents said the GP involved them in care decisions. This was higher than the local (CCG) average of 87%. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

GPs and nurses were able to demonstrate an understanding of Gillick guidelines used to help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge.

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

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of patients considered they were treated with care and concern during their consultation with the clinical team. This was higher than the CCG average of 90%. The 30 patients we spoke with on the day of our inspection and 18 comment cards we received were also consistent with this survey information.

Notices in the patient waiting room, told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice maintained a carer's register. A health care assistant was a trained carer support worker. One day a month this member of staff carried out health checks on patients who were also carers to ensure they received an annual health check. At these appointments the member of staff sign posted carers to relevant support services.

In the event of bereavement the named GP made contact with the patient's family to offer condolences and support to the family. The practice computer system ensured that letters were not sent out to deceased patients, thereby avoiding undue distress to family members.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We saw evidence that the practice management team involved the patient participation group (PPG) in the development of their patient survey and action plans in response to the feedback received. In March 2015 the practice conducted a survey which had 348 respondents. Patients told the practice that they would like longer opening hours at the branch surgery. The practice had responded by opening the branch practice on a Wednesday afternoon and had stopped closing at lunchtime in order to accommodate this.

Another improvement was the development of online facilities by the practice. The practice had signed up 1,497 patients to use their online service, which was an increase of 918 from the previous year. Online services included appointment booking, repeat prescriptions, cancellation of bookings, updating patient details and enabling patients to obtain a summary of their own medical records.

Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. The GPs had individual lists, to promote continuity, and attached staff paid tribute to the focus on continuity of care within this practice.

The practice had responded to the high numbers of older patients requiring leg ulcer treatment in the area by providing a leg ulcer clinic on a weekly basis. Staff included a leg ulcer specialist nurse and a health care assistant trained in leg ulcer dressing. Between April – June 2015 the clinic received seven patients who required compression bandaging. The practice leg ulcer clinic had completely healed four of these seven patients. The remaining three had made significant improvement and continued to attend the clinic.

Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. Temporary residents were welcomed.

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

The practice had level access to the front door which was automatic. Disabled toilet facilities were available. The GP consultation rooms and the treatment rooms were on the ground floor.

The seats in the waiting area were of different heights and size, some had arms on them. There was variation for diversity in physical health and some had arms on them to aid sitting or rising. A hearing aid induction audio loop was available for patients who were hard of hearing.

Access to the service

Appointments were available to be booked up to six weeks in advance and take place between 8.30am to 6pm. Patients told us they felt the appointment system was good. Extended hours were offered by the GPs and nurses on a weekly rota basis. Evening appointments were available from Monday to Thursday from 6.30pm until 7.45pm. Data from the last GP Patient Survey patient showed that 79% of 130 patients who responded were happy with the surgery's opening hours, compared to the local (CCG) average of 78%.

The practice operated a telephone triage system for patients who needed urgent appointments. A GP operated as duty doctor during morning surgery and could discuss needs with the patients and determine if an urgent appointment was required.

The practice varied the amount of appointments available depending on demand. Patients were able to book routine appointments up to six weeks in advance with a preferred GP. Extra appointments were also released on a daily basis. All of the patients we spoke with on the day of inspection confirmed that they had been able to make an appointment with their preferred GP. This aligned with the comment cards with individual positive references to the availability of appointments. The data we reviewed from the GP Patient Survey showed the practice had performed above the local and national averages in patient satisfaction with appointments. For example 95% of 130

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients who responded to the survey said they were able to get an appointment to see or speak to someone the last time they tried. This was higher than the CCG average of 91%.

Listening and learning from concerns and complaints

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

non-clinical complaints and liaised with GPs to manage all clinical complaints in the practice.

We saw that the complaints procedure was displayed on posters in the reception area and there was a complaints leaflet to help patients understand the complaints system. The practice had a complaints policy and maintained a complaints log. We looked at the complaints log for the last 12 months which recorded complaints received verbally, via email and in writing. The practice had received two medical complaints and 10 general complaints in the past year and we found that these been satisfactorily handled.

The practice reviewed complaints to detect themes or trends via an annual audit. Lessons learned and actions taken in response to the complaints received were discussed and shared with staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

There were clear vision and values, driven by quality and safety, which reflected compassion, dignity, respect and equality. The vision was to provide the best quality service to patients within a confidential, safe, timely, effective, efficient patient centred equitable environment.

There was a clear and realistic strategy which was discussed at team building days three a year and at monthly staff meetings. Staff knew and understood the vision, values and strategy. From a patient point of view the practice was working well and in keeping with their mission statement which was to deliver consistent quality of care to patients within available resources. GPs told us they regularly discussed the vision and values with all employed and attached staff including health visitors, midwives, community nurses and the patient participation group (PPG).

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The policies were reviewed annually and the network shared policies to ensure best practice. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GP leads for safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. Staff we spoke to told us that QOF dashboard data was regularly discussed each month at clinical meetings and development plans were produced to improve targets. The practice also held an annual clinical meeting to discuss QOF and plan activities for the forthcoming year.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

The practice had a programme of monthly practice team meetings. All practice meetings were minuted, emailed to staff and stored on the computer hard drive. 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.

We reviewed a number of policies and procedures, for example recruitment, induction and staff appraisal which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice also had a whistleblowing policy which was available to all staff electronically on any computer within the practice reviewed June 2015. Staff were aware of the whistleblowing policy if they wished to raise any concerns.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the GP patient survey which showed patients were satisfied with the care they received. For example 95% of 130 respondents said the last GP they saw or spoke to was good at treating them with care and concern this was higher than the local CCG average of 90%.

The practice had a patient participation group (PPG). The PPG currently had 210 members in their virtual on line group. The group met online and its main function was providing patient feedback and improvement suggestions to the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, staff had requested an additional administrator to work as a medical secretary. This had been implemented within three months of the request and a new member of staff was now in place.

Are services well-led?

Good

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

Management lead through learning and improvement

The practice embraced modern technology to drive service improvement. All clinical staff had instant access to National Institute of Health and Clinical Excellence (NICE) and British National Formulary (BNF) NICE guidance and BNF formulary applications on their mobile devices. The practice had purchased these applications for this purpose. This enabled GPs and nurses to provide all registered patients with the most up to date health care available. The practice had also installed wireless internet to enable this specific service improvement. This facility enabled GP's instant access to any updates on NICE guidelines, care and treatment.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice allocated protected time for discussions on referrals, results and prescribing and provided an opportunity for personal development and career progression.

We looked at three staff records including a GP, nurse and receptionist. We saw that regular appraisals took place for the clinical staff which identified areas for development with timescales for achieving these. Administrative staff had also had regular appraisals.

The practice closed for one day every quarter in response to a CCG incentive. This was allocated training time for all staff. The time was used for group training sessions and sometimes an outside trainer attended. Recent training included dementia training so that all staff were now dementia friends. Other training included annual emergency first aid training, information governance, child protection and safeguarding. Guest speakers had delivered presentations on dealing with challenging patients.