Richmond House Surgery

Quality Report

Richmond House Surgery
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Date of inspection visit: 12 May 2015
Date of publication: 24/09/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Richmond House Tuesday 12 May 2015.

Overall the practice is rated as good. It was also rated good for providing services for the six population groups.

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

There was a track record and a culture of promptly responding to incidents, near misses and complaints and using these events to learn and change systems so that patient care could be improved.

Staff were aware of their responsibilities in regard to consent, safeguarding and the Mental Capacity Act 2005 (MCA).

The practice was clean and tidy and there were infection control procedures in place.

Medicines were generally managed well at the practice and there were effective systems in place to deal with emergencies.

The GPs and other clinical staff were knowledgeable about how the decisions they made improved clinical outcomes for patients and kept patient care plans under review.

Data outcomes for patients were either equal to or above the average locally.

Patients were complimentary about the staff and how their medical conditions were managed.

Practice staff were professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. Adjustments were made to meet the needs of the patients and there was an effective appointment system in place which enabled a good access to the service.

There were clear recruitment processes in place. There were robust induction processes in place for all staff.

The practice had a vision and mission statement which were understood by staff.

Summary of findings

There was a leadership structure in place and staff felt supported by the practice manager and each other.

However there were areas of practice where the provider needs to make improvements

The provider should:

- Consider introducing arrangements or assessments to plan for the risk of sudden staff changes or to cover staff absence, including nursing and administrative staff.
- Consider ways of improving awareness of screening opportunities for chlamydia.
- Introduce a programme of internal appraisal and support for the practice manager.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff apart from the practice manager who received support from external sources. Staff worked with multidisciplinary teams of other health professionals.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patient feedback about the practice was good. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand.

We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to

Summary of findings

secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs.

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

Are services well-led?

Good

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

Despite the long term sickness of senior management staff morale remained high. Staff supported each other and felt supported by the practice manager.

The practice had a vision and strategy and staff were clear about their responsibilities in relation to this.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

Staff had received informal support and performance reviews. Staff attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

All patients aged 75 or over had an allocated GP, but also a choice as to which GP they see. The practice offered vaccinations against Influenza, pneumonia and shingles. The doctors and nurses undertook home visits for those patients who are unable to visit the surgery.

Practice staff held a Multi-Disciplinary Team (MDT) meeting once a month to discuss all patients that were particularly vulnerable or who were on the practice patient management list and referred patients to the community matron and team to assess and visit where necessary. The MDT group also discuss any palliative care patients to try and avoid unnecessary admissions to hospital. The practice referred patients to the local hub where health care professionals met and the community hospital if the patient required more care than they are able to get in their own home or a residential home but don't need to go into the district general hospital.

People with long term conditions

Good

The practice had systems to identify patients with long term conditions, who might be vulnerable or have complex and long term needs. These patients were discussed at monthly MDT meetings and were referred to the community matron and hub if required for further support.

Patients with long term conditions such as diabetes, heart disease, kidney disease, asthma, chronic obstructive pulmonary disease, rheumatoid arthritis and hypertension were invited for annual health reviews at a time to suit the patient. The practice nurses had the skills and knowledge to care for these patients and liaised with other health professionals if appropriate.

The practice nurse/nurse prescriber advised patients for weight management, smoking cessation and promoted independence and self-care where appropriate. The GPs visited patients who were housebound and unable to visit the practice.

Systems were in place for out of hours (OOH) providers to access summary care records for patients with long term conditions if the patient had given permission. The OOH provider then had up to date details of the patient's conditions and would be able to provide continuity of care.

Summary of findings

Families, children and young people

Good

Antenatal care was provided by local midwives who held a clinic at the practice every other Thursday morning. The midwives had access to the practice clinical system and a GP for advice. The health visiting and school nurse team attended the monthly MDT meetings to discuss any child who was on the at risk register and any patients/ families that the health visitor/school nurse or GP have concerns about.

The practice held child vaccination clinics every other Friday but could also book the child into a slot that was more convenient to the parent.

Working age people (including those recently retired and students)

Good

Patients requesting a call back from the GP were able to request this to be done at certain times of the day to suit their lifestyle and work pattern. The practice held a surgery on a Tuesday evening for those that were working during the day.

Patients were able to make online bookings and request a prescription and view their notes online following a formal request.

The practice offered NHS health checks, smoking cessation, weight management, well woman/man checks and carer's checks to eligible patients.

Patients were able to order their prescriptions online, through the website, via email, post or fax if they were unable to visit the surgery. They were able to pick up the script at the chemist of their choice which could be nearer to their workplace.

People whose circumstances may make them vulnerable

Good

Vulnerable patients were discussed at the MDT meeting if the GP or nurses had any concerns to raise with other MDT members.

The practice cared for two learning disabilities care homes and a care home for patients with Korsakoffs syndrome (alcoholic dementia). The GPs visit these patients when they are acutely unwell and also visit annually to do a health check and medication review for each patient. Patients with learning disabilities or with mental health problems were offered an annual review.

All staff were up to date on the appropriate level of safeguarding.

People experiencing poor mental health (including people with dementia)

Good

The practice had a mental health and dementia register. These patients were offered an annual health and medication review either at the practice or in the patient's home if they were unable to attend the practice.

Summary of findings

The practice had an in house counsellor and referred to the Depression and Anxiety Service who used a room a surgery if the patients could not go to them. The GPs referred patients to the drug and alcohol services and child and adolescent mental health service when required.

Regular blood tests were performed for patients on certain mental health drugs and recalls were set up to make sure that these patients were invited.

The practice had identified all patients who were thought to be at risk of dementia. This system was updated regularly and a popup was placed on the patients notes to remind the clinical staff to offer a screening test for dementia.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection and with two members of the patient participation group.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 30 comment cards, all of which contained positive comments. There were no negative comments.

Comment cards were detailed and stated that patients appreciated the helpful staff, caring and respectful service provided, the clean and tidy building and praised the GPs, reception staff and nurses. Patients referred to being happy, very happy, delighted and grateful for the attention and care.

These findings were reflected during our conversations with the 10 patients we spoke with and from looking at the practice's 152 friends and family test results from January 2015 to March 2015 and from the practice patient survey from March 2014. The feedback from patients was consistently good. Patients told us about their experiences of care and praised the level of individual care and support they received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent. Of the 152 friends and family test results we saw 144 patients said they were extremely likely or likely to recommend the practice. There were 8 other results which stated patients were neither likely nor unlikely. None said they would be extremely unlikely to recommend the practice. There were many positive comments to support the findings. Two patients commented that getting to see the GP of their choice was sometimes a problem.

Patients were happy with the appointment system. Patients said that the 'doctor first' telephone triage system worked well and had enhanced the service. We were told patients could make an appointment on the day and be seen following discussion with the GP. Parents said they could always make a same day appointment for their children. We were told that no patient would be turned away.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients said they found it easy to get repeat prescriptions processed.

Areas for improvement

Action the service SHOULD take to improve

- Consider introducing arrangements or assessments to plan for the risk of sudden staff changes or to cover staff absence, including nursing and administrative staff.
- Consider ways of improving awareness of screening opportunities for chlamydia.
- Introduce an internal programme of appraisal and support for the practice manager.

Richmond House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to Richmond House Surgery

Richmond House was inspected on Tuesday 12 May 2015. This was a comprehensive inspection.

Richmond House is situated in the seaside town of Teignmouth, Devon. The practice provides a primary medical service to approximately 2,850 patients of a diverse age group including a higher percentage of older people.

This practice has two partners, a GP and business manager. Partners hold managerial and financial responsibility for running the business. The two partners had both been on long term absence so have been supported by two salaried GPs, one of whom has increased the number of sessions offered. Including the GP partners there are one male and two female GPs. The GPs are supported by a practice manager, a nurse prescriber and a phlebotomist. The clinical team were supported by additional reception, secretarial and administration staff.

Patients using the practice also have access to community staff including community matron, district 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 8.00am and 6.30pm and open for patients between 8.30am and 6pm. Appointments can be accessed in advance and take place between 8.30am and 5.30pm. The practice uses an appointment system called 'Dr First' where patients phone the surgery for an appointment and are placed on the doctors call back list. The GP then rings the patient back that day at a time specified by the patient, either dealing with the query on the phone or making a face to face appointment. Outside of these times the GPs make telephone calls and see patients that have been triaged. The practice offers extended appointments on Tuesday evenings between 6.30 and 8.00pm.

The practice has opted out of providing out-of-hours services to their own patients and refers them to an out of hour's service.

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.

Detailed findings

How we carried out this inspection

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

• Is it safe?

• 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

• Mothers, babies, children and young people

• The working-age population and those recently retired

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

• People experiencing poor mental health

Before conducting our announced inspection of Richmond House, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local NEW Devon Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Tuesday 12 May 2015. We spoke with 10 patients, two GPs, the nurse prescriber and members of the management, reception and administration team. We collected 30 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, nursing staff said they were expected to record the incident and report to the practice manager who then coordinated the response.

We reviewed incident reports, significant analysis and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently and could show evidence of a system to monitor 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, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the monthly practice meeting agenda to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, a record keeping incident regarding recalling patients resulted in staff being reminded to inform patients to contact the practice to make an appointment or obtain results. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms at the practice and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, the learning outcome for a clinical event had resulted in staff making more detailed records when minor operations are performed. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. For example following a medicines error.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings and at practice meetings if relevant to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. In the absence of the GP partner, staff referred any safeguarding concerns to the practice manager who was coordinating safeguarding issues but also discussed with the other GPs. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern when the lead GP was not available.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff acted as chaperone where necessary and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Good

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

The nurse prescriber had introduced systems and processes to check medicines were available, within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations, including hormonal treatments which require additional disposal facilities.

The practice used documents called patient group directives and patient specific directions to enable nurses and the health care assistant to administer vaccines in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines and had signed the directives giving them permission to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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 and these were tracked through the practice and kept securely at all times. The practice had a system in place for reviewing repeat medications. If the limit of authorised prescriptions had been reached, the computer prevented the prescription from being printing. This was then passed to the doctor for review, and re-authorisation if appropriate.

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a new lead 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 received induction training about infection control specific to their role and received annual updates. The new nurse prescriber had highlighted that an infection control audit was due and performed this the day following the inspection. The results of this were sent to us the following day. The audit had highlighted the need to introduce disposable mop heads and introduction of hand washing posters in one of the toilets. The audit also highlighted issues raised during the inspection which included ensuring clinical waste bins were secure.

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, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff toilets and were introduced following the audit. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice had assessed the risk of this and ran taps in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The practice had a contract with the Royal Devon & Exeter Hospital Trusts Medtronics Department to manage the asset register, maintenance, calibration and repair of all medical equipment.

Good

Are services safe?

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was booked to take place later in the month.

Staffing and recruitment

We looked at five staff files which showed that appropriate recruitment checks had been undertaken on nursing staff, salaried GPs and administration staff prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Newly appointed staff had this expectation written in their contracts.

Staff told us there had been long term absence of both partners at the practice and recent departure of a member of the nursing team who had not been replaced which had placed additional pressure on the whole staff team. The GP partner explained options were in the process of being discussed. Not all staff were yet aware of these plans.

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. However, staff also said this had been because staff had 'pulled together' to meet the needs of patients. There were no formal arrangements or assessment in place to plan for the risk of sudden staff changes or to cover staff absence, including nursing and administrative staff.

Patient feedback in March 2014 highlighted that patients did not like to be 'put on hold' when calling the practice in the morning. The practice stated that additional administration staff were available during busy times. However, during the inspection we noted that patients were still being placed 'on hold' whilst the efficient receptionist managed a high volume of other patient questions. The additional administrator was also busy and unable to assist.

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. Health and safety training took place with other practices in the town and was included on the annual mandatory update training session. Health and safety information was displayed for staff to see and there was an identified health and safety representative who performed regular checks in and outside of the building. Accidents are recorded by staff. No significant entries or reports required to notify RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) had taken pace.

Identified risks were included on a risk log and were discussed at GP partners' meetings and within team meetings.

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. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The new nurse prescriber had introduced a process which recorded these checks.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, and access to the building. On the day of inspection, the plan was put into action when the computer system failed. The practice staff were calm and used the information held to contact the clinical system provider who gave instructions to restart the system successfully.

The document contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The document did not initially include details of what facilities or building would be used in the event of an emergency. However, this was introduced by the end of the inspection.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and showed the last fire drill had been carried out in April 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 online guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff said any changes in guidelines were disseminated, discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. For example, following best practice guidelines for travel vaccines.

The nurse prescriber led in specialist clinical areas such as diabetes, heart disease and asthma and was supported by the GPs. Clinical staff we spoke with were open about asking external health care professionals for and providing practice colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions.

Data showed us that practice's performance for antibiotic prescribing was comparable to similar practices in the CCG. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within a week by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers. Of the 61 referrals six patients had not been seen on time. Four of these were under the control of the patient. For example, patient choice, transport difficulties or failing to attend. The remaining two were followed up by the practice. We saw records of audits which showed these referrals were kept under review and shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Individual staff and the practice manager had key roles in monitoring and improving outcomes for patients and had taken on additional roles in the absence of the GP partner and business partner. 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 ensure the care was effective.

The practice showed us evidence or described seven clinical audits that had been undertaken in the last three years. All seven of these were audits relating to CCG prescribing monitoring and were completed audits. Three of the seven audits demonstrated the changes that had been put into place since the initial audit and the remaining four had identified that further action was not required. Only two of the seven audits had been re-audited to show a complete cycle had taken place. We saw another audit to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of medicines for chronic kidney disease (CKD). The audit sampled 25 of the 152 patients with CKD, to check whether they had had the required urine test, and whether the stage of the CKD was correctly recorded. We saw that two of the 25 patients had not had the urine test. A higher proportion had an incorrect stage recorded. This audit was well documented but there was no mention as to whether it had led to any action. Another audit included a study of patients taking medicines to treat

Good

Are services effective?

(for example, treatment is effective)

high blood pressure and heart failure and was to check whether they had a blood creatinine check in the last year. We saw details to show that patients had been recalled if they had not had the test.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 88.69% of patients with diabetes had an annual medication review, and 86.66% of patients with chronic obstructive pulmonary disease (lung disease) had received a medicines review. This practice was not an outlier for any QOF (or other national) clinical targets.

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. We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. The practice manager provided the most recent prescribing data from the CCG Cost Effective & Quality prescribing scheme. This showed the practice were just below budget, and about average for the CCG. For example, prescribing of the preferred type of hypnotic was good; prescribing of the preferred brand of laxatives was somewhat below target but within the acceptable range. We saw action plans had been introduce to change medicines where performance was below average for the CCG. For example, changing the needles used for diabetics.

They checked and reported that all routine health checks had been 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. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, 98.39% of patients with diabetes had received an influenza vaccine compared with the national rate of 93.49%.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. The GP partner had a special interest in chronic disease management including diabetes. She was also the Medical Officer for Teignmouth Royal national lifeboat institution (RNLI) and a part-time Clinical Tutor at the Peninsula College for Medicine and Dentistry. The GPs we spoke with were up to date with their yearly continuing professional development requirements and all either have 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).

Reception staff and nursing staff said they felt supported by each other and by the practice manager and said they could access any training they needed. Staff said support was mostly informal as the practice manager had an open door policy and spoke with them on a daily basis. Staff explained that they were due their formal appraisal but understood they could speak with the practice manager about employment issues at any time. The practice manager received support from other practice managers in the town and from the local medical council but had not had an appraisal for a number of years. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a member of the nursing team had left recently and the nurse prescriber was able to attend updates and training to ensure she was able to care for patients with all long term conditions.

The practice was not a training practice for GP trainees but they had supported medical students.

Good

Are services effective?

(for example, treatment is effective)

The nurse prescriber was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, and travel vaccines. The nurse had extended roles including seeing patients with long-term conditions such as asthma, Chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease. She was also able to demonstrate that they had appropriate training to fulfil these roles.

The two partners had been absent from the practice for many months. The practice manager had taken over the management of the practice and had been given some short term support from a practice manager and the local medical council pastoral care team. Staff said the partner absences had placed a large amount of additional pressure on the staff team but they had worked together to make sure patient care remained unaffected. We spoke with staff about cover when staff were off sick or on leave. Staff explained that they tended to cover for each other but this was now not possible as other staff had retired. For example the practice nurse was the only practice nurse employed. There were no arrangements or assessments seen to plan for the risk of sudden staff changes or to cover staff absence, including nursing and administrative staff.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately. We saw details of a significant event where communication of the results of a blood test had not been done in line with practice policy. Records showed that action included a review of the policy and staff being reminded to follow the instructions.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice were part of a 'rota of GPs' who cared for patients in the local cottage hospital.

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

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 61 fast track referrals last year through the local system. Staff reported that this system was easy to use and keep under review.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Staff also stated that there was a plan to change system to one that is used by more care providers. Staff explained that the practice aimed to be paper free and that any correspondence was scanned and saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Any patients with mental capacity issues were discussed at the MDT meetings. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs were able to provide scenarios where they had involved independent mental capacity advocates and had attended best interest meetings. When interviewed, staff gave examples of how a patient's best interests were

Good

Are services effective?

(for example, treatment is effective)

taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Data showed us that 24 of the 26 patients registered with a learning disability had had an annual health care review in the last year.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in 100% of cases.

Health promotion and prevention

The practice were active in health promotion in the town and held events when providing flu clinics. The practice had held a 'Love Living in Teignmouth' healthcare promotion day in November 2014 and facilitated members of 23 local organisations, including social groups, NHS services, community centres and local charities to speak with patients about activities and services available to enrich their lives in the local community. Patients were also advised about cancer, heart disease, smoking cessation and asthma.

The practice offered all 40 - 75 year olds health checks and had invited 30.58% of eligible patients to this screening. So far 62.54% of those patients had received an NHS health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 24 out of 26 had received an annual physical health check. The practice had also identified the smoking status of patients aged 15yrs and above. Of these 97.65% had been recorded as being offered smoking cessation advice. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 6.75%, which was above average compared to neighbouring practices and national figures.

The practice's performance for cervical smear uptake was 80.80%, which was better than others in the CCG area. There was a policy to offer telephone reminders and letters for patients who did not attend for cervical smears and monitor patients who do not attend. However, we noted that the practice has a very low rate for chlamydia screening in 15-25 year olds (only about 1%). It is possible that some of these patients had screened themselves with self-test kits available in pharmacies and some youth clinics (results of these are sent confidentially to the patient, and not to the practice). However, there was no evidence that the practice had promoted these kits – there were no posters, nor any kits on display. Performance for national mammography and bowel cancer screening in the area were all above average for the CCG. For example, the practice had screened 63.54% of patients for breast cancer in the last three years and 33.27% of patients aged 60-69 years for bowel cancer and had a mechanism in place to follow up patients who did 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 above average for the CCG. For example, the practice were in the top three practices for seasonal flu vaccines for children between the ages of two and four years. There was a clear policy for following up non-attenders by the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the survey of 93 patients undertaken by the practice's patient participation group (PPG) in March 2014 and the 152 friends and family results from January 2015 to March 2015. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the PPG survey showed that patients felt that 88% of GPs, 91% of nurses and 90% of reception staff were polite, efficient and helpful.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We did not receive any negative comments. We also spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 / treatment 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. The practice switchboard was located in the waiting area. However, we noted that the receptionist spoke in a way which helped keep patient information private. In response to patient and staff suggestions, background music had been introduced to help distract patients from conversations being held at the reception desk. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

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 PPG survey showed 84% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results.

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.

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. The patient comment cards we received were also consistent with this survey information. For example, these highlighted that patients 'enjoyed' coming to the practice and considered it a positive experience.

Notices in the patient waiting room, on the TV screen and patient website also 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. Any carers of vulnerable or palliative care patients were discussed at the monthly MDT meetings to assess whether

Good

Are services caring?

additional support was required. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer any additional support.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice engaged with NHS England Area Team and the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example the practice had met with other practices to see how research facilities could be improved.

The practice was part of the Primary Care Research Network (a non-commercial NHS scheme in partnership with the University of Exeter). The practice submitted, with permission, data from records of existing patients, or recruited patients to a study. Patients were provided with literature regarding the current studies taking place.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had introduced creative ways of supporting these groups. For example the introduction of health promotion events and the facility to have all long term conditions reviewed at one extended appointment.

The practice informed us that the number of patients who did not speak English was low but explained that they had access to online and telephone translation services.

The practice was situated in a small converted terrace house in the town centre which did not have facilities for a passenger lift. The practice ensured that patients with mobility issues were seen in a ground floor consulting or treatment room.

We saw that the waiting area was just large enough to accommodate patients with wheelchairs and prams and easy access to the treatment and consultation rooms. Ground floor accessible toilet facilities were available for patients attending the practice including baby changing facilities.

Access to the service

The practice was open from Monday to Friday, between the hours of 8.00am and 6.30pm and open for patients between 8.30am and 6.30pm. Appointments can be accessed in advance and take place between 8.30am and 5.30pm. The practice used an appointment system called 'Dr First' where patients phone the surgery for an appointment and are placed on the doctors call back list. The GP then rings the patient back that day at a time specified by the patient, either dealing with the query on the phone or making a face to face appointment. Outside of these times the GPs make telephone calls and see patients that have been triaged. The practice offered extended appointments on Tuesday evenings between 6.30 and 8.00pm.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hour's service.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments with the nurse or GP were also available for patients who needed them and those with long-term conditions. Home visits were made to four local care homes, by a named GP and to those patients who needed one. The GPs provided annual health reviews of these patients, including patients with Korsakoffs syndrome (alcoholic dementia)

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to but said they also said they could see another doctor of their choice if they could wait for a couple of days. Comments received from patients showed that patients in urgent need of treatment were able to speak to a GP and be seen on the same day of contacting the practice.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

explained in a patient leaflet and were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that a poster and leaflets on the reception desk were available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, and demonstrated openness and transparency when dealing with the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. For example, any clinical issues had been discussed by clinicians and patients given an explanation where required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. We found details of the aims and objectives of the practice which were included in the practice statement of purpose. These included understanding patient expectations and provide the highest standard of clinical care possible.

We spoke with five members of staff and they were aware of these aims and knew what their responsibilities were in relation to these and agreed that as a team they provided this service.

Governance arrangements

The practice manager had maintained 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. Staff were all aware of where to find these policies and had a role in updating them. Staff told us that any updates were emailed to the team.

There was a leadership structure in place with named members of staff in lead roles. However, the long term absence of the two partners had resulted in staff having to take on additional roles and responsibilities. Staff told us they felt valued and well supported by the practice manager and each other and had pulled together and worked hard through a difficult time.

The practice manager used QOF to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly meetings and action plans were produced to maintain or improve outcomes where necessary.

The practice performed clinical audits which were used to monitor quality and systems in order to identify where action should be taken. However, we noted that these were often linked to medicines management information, safety alerts or as a result of information from QOF.

The practice manager held monthly meetings where governance issues were discussed. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly although discussions took place more often. Staff told us that they could raise issues with the practice manager at any time, although they felt the practice manager had not always had the power to act in the long term absence of the two partners.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the disciplinary procedures and whistleblowing policy which were in place to support staff.

Seeking and acting on feedback from patients, public and staff

The practice population was small and patients were able to give feedback informally. Staff explained that any comments were passed to the practice manager who usually dealt with them promptly. The practice manager also used patient surveys, comments from the friends and family results and complaints to gain feedback.

The practice had an active patient participation group (PPG). The 12 PPG members were between the ages of 40 and 89 and met several times a year, generally every 2 months. The group were actively trying to engage with younger patients via social media sites and the surgery website and were in the process of introducing a newsletter for patients. The group told us they assisted the practice manager with promoting the group and had actively helped with flu days and a carer's awareness week. The group told us they had also assisted patients to complete a patient satisfaction survey and were currently planning a health promotion event which will be held to give skin cancer advice and the dangers of unprotected skin in hot weather.

The practice manager gathered feedback from staff through daily conversations and through team meetings. Staff told us the practice manager was approachable and that they would not hesitate to give feedback and discuss any concerns or issues. Staff told us the support came from the practice manager and from themselves and had not always been given opportunities to be involved and engaged by the partners.

Management lead through learning and improvement

Administration and nursing staff told us that the practice supported them to maintain their clinical professional development through training but knew they were due for

Are services well-led?

Good

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

reappraisal. The practice manager explained that she had been aware of this shortfall and had dates booked. However, the absence of both partners and additional tasks and roles had distracted from this. Staff said despite not having appraisals training needs continued to be identified and facilitated and support give more informally. We noted that the practice manager had not received formal support or appraisal from the partners for a number of years.