Shipdham Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Shipdham Surgery has a practice population of approximately 3580 patients. The surgery offers a medicine dispensing service for patients who lived in excess of one mile of a pharmacy.

We carried out a comprehensive inspection at Shipdham Surgery on 4 November 2014.

We have rated each section of our findings for each key area. We found that the practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because the practice staff demonstrated enthusiasm and worked together in providing comprehensive care for patients. Since their employment the practice manager had made significant improvements and had identified where further work was needed in the day to day operations of the practice. For example, arrangements had been made for staff to attend a range of training courses to ensure they had appropriate knowledge and skills to carry out their roles effectively.

Our key findings were as follows:

- We found evidence that the practice staff worked together well to make ongoing improvements for the benefit of patients.
- The senior GP had developed a register of all vulnerable patients and was carrying out an audit of each patient as part of the hospital admission avoidance scheme.
- The practice was able to demonstrate a good track record for safety. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.
- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were very satisfied with the care they received.

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

Practice staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Untoward incidents were investigated and 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. The recruitment practices were robust and there were enough staff to keep people safe. Patients were protected by safe mechanisms for dispensing their prescribed medicines.

Are services effective?

Good

The practice staff had procedures in place to deliver care and treatment to patients in line with best practice. Practice staff carried out clinical audits and as a result made changes where necessary to promote effective care for patients. Practice staff had commenced multidisciplinary meetings and joint working in delivery of effective and up to date patient care. Systems were in place for regular reviews of patients who had long term conditions and housebound patients.

Are services caring?

Good

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. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. We observed staff interacting with patients in a caring, supportive and respectful way.

Are services responsive to people's needs?

Good

The practice demonstrated how they listened to and responded to their patient group. We saw that efforts had been made to reach out to each population group to ensure they received appropriate care and treatments. There was a system in place which supported patients to raise a complaint. Complaints received had been recorded, investigated and responded to in a timely and appropriate way. The layout of the premises supported access for patients who had restricted mobility.

Are services well-led?

Good

The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with

Summary of findings

staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there were high levels of constructive staff engagement and a high level of staff satisfaction.

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 had a higher than average number of older patients. This impacted on the number of home visits that GPs needed to do. Practice staff carried out regular health checks of patients who had chronic diseases. We found these were well organised to ensure patients received care when they needed it. All patients aged over the age of 75 years have been informed of their named and accountable GP. GPs provided a service to the local residential care home. During our inspection we saw how a GP promptly responded to the needs of a resident.

People with long term conditions

Good

The practice staff held a register of patients who had long term conditions. The necessary tests and investigations required were organised beforehand to ensure all information was to hand for the reviews. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice specifically reviewed unplanned hospital admissions for this group so that lessons could be learnt.

Families, children and young people

Good

The practice staff worked with local health visitors in providing child immunisations. Community midwives held ante natal clinics at the practice every week. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, GPs reviewed the patient notes of any children and young people each time they had attended the hospital A&E department.

Working age people (including those recently retired and students)

Good

Patients who needed referrals were offered choices about which hospital they wished to be referred to. Patients were able to hold telephone consultations to receive advice and guidance from GPs about whether they needed to be seen. The practice did not have extended opening times. However, we asked patients about this and they all commented that they were satisfied with the times they were able to access the practice.

People whose circumstances may make them vulnerable

Good

The practice had identified patients with learning disabilities and treated them appropriately. We found that all patients in this group

Summary of findings

had received annual health checks. A translation service was available for patients whose first language was not English. GPs carried out regular home visits to patients who were housebound and to other patients on the day they had requested the visit. Practice staff encouraged patients to participate in health promotion and information about healthy eating was available in the waiting area. There was a system in place to encourage patients to attend their reviews and those who did not attend were followed up.

People experiencing poor mental health (including people with dementia)

Good

Patients who presented with anxiety and depression were assessed and managed in with the National Institute for Clinical Excellence (NICE) guidelines. The practice worked in conjunction with the local mental health team. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. All staff had received training in the Mental Capacity Act 2005 so they would have appropriate skills for dealing with patients with dementia.

Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection who varied in age. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all reported they were happy with the standards of care they received. We were told it was easy to obtain repeat prescriptions. Some patients told us they had to wait after they arrived to see a specific GP but they were happy to wait because they felt the GP listened and took time with them to ensure their health needs were met. We did not receive any negative comments from the patients we spoke with.

Prior to the inspection we provided the practice with a box and comment cards inviting patients to tell us about their care. Although they were placed in a prominent position, we did not receive any completed comment cards.

We spoke with the chair and another member of the Patient Participation Group (PPG). PPGs are an effective way for patients and surgeries to work together to improve services and promote quality care. They told us they had just recently formed the group and had only held one meeting. They told us they and practice staff were positive about ensuring patients received good care. They told us about their aim to get more involved with the wider community and to formulate a luncheon club for patients who felt lonely. The PPG members and the practice manager told us they were looking towards carrying out a patient survey during the summer of 2015. The members also commented about the care they received as patients. They told us they could not overstate the standards the practice staff provided and the ease in obtaining repeat medicines from the dispensary.

Areas for improvement

Action the service SHOULD take to improve

- The layout of the premises meant that patients and cleaning staff had free access to the dispensary and the room where dispensed medicines were stored. Arrangements should be made to ensure the safe storage of medicines.

Shipdham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP who was a specialist advisor.

Background to Shipdham Surgery

Shipdham Surgery served approximately 3580 patients.

At the time of our inspection there were two GP partners and a salaried GP at the practice. A salaried GP is a doctor who may later be made a partner. There were two female doctors. The GPs provided 16 sessions a week to meet patient's needs. There was a trainee nurse practitioner and a practice and two health care assistants who were employed to work varying hours. The practice manager, assistant practice manager, dispensary manager and reception manager were responsible for the management of six reception/dispensing staff who were also employed to work varying hours. An apprentice receptionist was working full time at the practice.

The practice offered a range of clinics and services including chronic disease management, cervical smears, contraception, minor surgery, diabetic and nurse smoking cessation clinics.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 November 2014. During our visit we spoke with a range of staff including two GPs, the trainee nurse practitioner, the

Detailed findings

practice manager and assistant practice manager, the dispensary manager and three reception/dispensing staff. We also spoke with patients 11 who used the service and chair and a member of the Patient Participation Group (PPG) who acted as patient advocates in driving up improvements. We observed how people were being cared and how staff interacted with them and reviewed personal care or treatment records of patients. We observed how staff interacted with patients and how a GP responded to a request to attend the local care home to assess an ill patient.

Good

Are services safe?

Our findings

Safe Track Record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, an inappropriate change of medicine for a child. The error was detected before the new medicine had been taken by the patient. A system was put in place to double check the prescribing to prevent a recurrence.

We reviewed safety records and incident reports and saw how the practice manager recorded incidents and ensured they were investigated. The partners held an annual meeting to review the practice's safety record over the previous year and to check that the actions taken had been effective.

When a child had attended the Accident and Emergency department of the local hospital GPs checked through the patient records and assessed the safety risk to these patients. If they were concerned about a child's safety the GP would discuss their findings with the health visitor or report it to the local authority.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff recorded incidents as soon as they occurred. The practice manager formally recorded the incidents and commenced the investigations.

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The practice staff had notified the Clinical Commissioning Group (CCG) of individual events. The CCG are responsible for monitoring the standards of the services provided by practices.

We were given some sample significant event audits. These clearly stated the investigations carried out, the resultant actions and which staff the information had been cascaded to. The records we saw told us they had been completed in a comprehensive way.

Reliable safety systems and processes including safeguarding

Senior staff had policies and systems in place to ensure that patients were safeguarded against the risk of abuse. There was a named GP lead for safeguarding. We saw that reception/dispensing staff had not received training in safeguarding children and adults. The practice manager who had been employed for 18 months had identified this as a problem and had arranged for staff to receive the necessary training. Staff confirmed they had access to the written policies and were able to demonstrate what action they would take if they were concerned about a patient's safety. Information about the local authority's safeguarding process was readily available. We saw that there was information and contact details in the waiting area for patients to use if they had concerns about their safety.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, we saw that a GP had attended a multidisciplinary team meeting about a child's safety and another where an investigation was in progress.

Medicines Management

We found that medicines management was safe. Repeat prescriptions could be requested by telephone, on-line, by post or by leaving the repeat request tear off slip at the practice. There was a delivery service for patients who did not need to pay for their prescriptions. The patients' leaflet stated that it took two full days or three if the request was made during the afternoon for medicines to be ready for collection. The patients we spoke with told us there was no delay in getting their prescriptions.

The dispensary manager showed us the whole process for dispensing prescribed medicines. All prescriptions were signed by a doctor before the medicines were dispensed. To prevent errors from occurring a second dispenser checked that all medicines had been dispensed correctly before the instructions were printed and applied to the containers. The dispensing staff made up medicines for some patients in dossette boxes to prevent patient confusion when they needed to take their medicines.

Good

Are services safe?

Any errors or incidents were recorded and some had been escalated to significant events for full investigations and where appropriate resultant actions had been taken to prevent similar recurrences. This meant they had disseminated to other staff.

Audits in relation to medicine management practices had been carried out. Where improvements were identified staff had put systems in place to address them.

The key to the controlled drug (CD) cabinet was kept in a safe place. Checks on the CD's were carried out every month and every three months by a GP. We found that the CD's were safely stored and dispensed safely and the recordings were appropriate.

The drug fridge temperatures had been recorded each day and were kept within normal limits as per manufacturer's guidance to ensure that remained stable and fit for administration.

The prescribing and medicines management team visited the practice annually to audit the dispensing arrangements. The dispensary manager also carried out regular audits to ensure staff practices were safe.

The layout of the premises meant that patients and cleaning staff had free access to the dispensary and the room where dispensed medicines were stored. Arrangements should be made to ensure the safe storage of medicines.

Emergency equipment and medicines were stored safely and regularly checked to ensure they remained in date and fit for use.

Each doctor had their own visit bag. We saw that the senior GP had a list of medicines they carried and when they would need replacing. We were unable to check that the other GPs had an auditing system in place. The senior GP assured us they would explore this to make sure all medicines carried in GP's bags were safe for use.

Cleanliness & Infection Control

We saw that all areas of the practice were clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We were shown the cleaning schedule for staff to follow.

The practice had a lead for infection control who had received some training for this role and had made arrangements to attend more detailed training. All other staff had received training in infection control. The lead had been employed for a short time and was aware they needed to develop and audit tool for checking the standards of hygiene throughout the practice.

We asked if they had made any changes since their employment had commenced. They told us they had introduced a dedicated fridge for storing samples for testing, equipment was stored in more hygienic places and the cleaning materials had been improved. We saw minutes of meetings where these improvements had been discussed with all other staff.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff confirmed there were always good stocks of PPE within the practice. There was also a policy for needle stick injury.

We found that a Legionella risk assessment had not been carried out but the practice had a water dispenser in the waiting area for patients to access. The practice manager had put signs up at all taps that patients had access to advising them not to drink tap water. There were recordings for the weekly flushing of taps and shower heads that were not in regular use.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and appropriate recordings maintained.

Staffing & Recruitment

Senior staff based staffing requirements on the current demands of patient care. Regular consideration was given by checking whether enough GP sessions were available to meet patient demands. The practice had recently accepted 335 extra patients from another practice and had

responded by employing a salaried GP and a part time trainee nurse practitioner. The practice manager told us they anticipated there would be a greater demand for the practice to increase.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and reception/dispensing staff to cover each other's annual leave. 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 ensure patients were kept safe. Patients told us they did not have difficulties in obtaining appointments when they needed to.

Records we looked at contained evidence that appropriate 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. The practice had a recruitment policy that set out brief details for recruiting clinical and non-clinical staff.

Monitoring Safety & 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 risk assessments of the environment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, practice staff monitored repeat prescribing for people receiving medication for mental health needs.

Arrangements to deal with emergencies and major incidents

We saw the business continuity plan. The document detailed the actions that should be taken in the event of a major failure and contact details of emergency service who could provide assistance. Copies of the document were held off site by the practice manager and the senior GP. The senior GP told us they were going to put the business continuity plan on a computer disk and give a copy to each GP. The document covered eventualities such as loss of computer and essential utilities. The plan was clear in providing staff guidance about how they should respond. It included the contact details of services that may be able to help at short notice.

A fire risk assessment had been undertaken that included actions required for maintaining fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Risks assessments associated with the premises had been carried out.

The patient leaflet and the telephone when the practice was closed gave information about how to access urgent medical treatment when the surgery was closed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The staff we spoke with and evidence we reviewed confirmed that staff actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with the National Institute of Care Excellence (NICE) guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the prevention of unnecessary hospital admissions. We saw that the followed a system of scoring the risk values to identify how vulnerable patients were management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened. This would permit GP's to identify the most appropriate resource to refer patients to.

The practice GPs had developed a system of holding 15 minute appointments for all patients to ensure they captured all the relevant information needed to assist with decision making for patients with complex needs.

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.

Management, monitoring and improving outcomes for people

Practice staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care. We were shown the latest QOF achievements that told us practice staff were meeting all of the national standards.

Practice staff had a system in place for carrying out clinical audits. One audit concerned a review of the use of a medicine and the actions that had been taken as a result of the audit. Practice staff had recently commenced the next audit to review the impact from the changes made in the first audit. A GP had carried out an audit for patients who had been given orthopaedic referrals. The result was that patients had waited too long to be assessed by physiotherapists. The GP had made a recommendation for this aspect of care to be reviewed.

GP's held a weekly meeting to review the hospital admissions to ensure they were justified. Practice staff were in the process of auditing all vulnerable patients to identify those who were at high risk of being admitted to hospital. Reviews of those patients identified were in progress. An audit of the rationale and numbers of patients who had been referred to gastro-enterology (stomach) hospital departments. The result showed a low number of referrals had been made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that some staff were not up to date with attending the training courses such as annual basic life support. The practice manager had identified this as a need when they were appointed and had made arrangements for staff to attend a range of training courses by the end of 2014. All GPs had completed their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw that nurse's and health care assistant's appraisals had been booked to be carried out by mid November 2014. Their appraisals were carried out by clinical staff so that their practices could be discussed and checked. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example specialist asthma training for the trainee nurse practitioner.

Working with colleagues and other services

There was evidence of appropriate multidisciplinary team working and there were strong relationships in place. Prior

Good

Are services effective?

(for example, treatment is effective)

to the appointment of the practice manager 18 months ago there had been no multidisciplinary meetings was held. However, two meetings that had recently been held but minutes had not been made. The practice manager told us they would arrange for multidisciplinary and palliative care meetings to be held every three months and these would be recorded. They informed us that community staff invited to attend would be Macmillan nurses, the community matron and district nurses.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon 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 per year.

Patients were invited to contact the practice to receive their results. However, if a test was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

For patients who had attended an out of hours service or following discharge from hospital we were told that the respective GP reviewed the information provided to them on a daily basis. A GP told us that if patient's required follow up they would send a request to the patient for them to make an appointment. If necessary a referral would be made to a hospital or another health department.

Consent to care and treatment

We spoke with 11 patients and they all confirmed they felt in control of the care because they had been well informed about their illnesses and treatment options. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure. We were told that consent forms were signed only after full explanations had been given to patients.

GPs were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked capacity to make informed decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

They also knew how to assess the competency of children and young people about their ability to make decisions about their own treatments. Clinical staff understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged less than 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

The practice manager told us all new patients were offered a health check and a review of any illness and medicines they were taking.

Patients who were due for health reviews were sent a reminder and if necessary contacted and asked to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. There were also folders containing advice on healthy eating.

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 learning disabilities (LD) and they were offered an annual physical health check. The achievement for this aspect of care was 100% uptake of health reviews for patients with learning disabilities.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed that reception/dispensary staff greeted patients in a polite and courteous manner. When appointments were made by telephone we overheard receptionists giving patients choices and respected when patients were available to attend on some days. We also noted that reception/dispensary staff were helpful when patients arrived to collect their repeat prescriptions.

We observed patients being treated with dignity and respect throughout the time we spent at the practice. We saw that clinical staff displayed a positive and friendly attitude towards patients. Patients we spoke with told us they had developed positive relationships with clinical staff who were familiar with their health needs.

Patients confirmed they knew their rights about requesting a chaperone but they commented this service was offered to them by clinical staff. Some people had used the chaperone service and reported to us they felt quite comfortable during the procedure.

There was a privacy and dignity policy in place and all staff had access to this. We saw that all clinical rooms had window blinds and privacy screening. Clinical staff told us the consulting room door was kept closed when patients were being seen. We observed staff knocking on doors and waiting to be called into the room before entering.

Care planning and involvement in decisions about care and treatment

Patients were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. The patients we spoke with told us they were able to make informed decisions about their care and felt in control.

The Mental Capacity Act 2005 governs decision making on behalf of adults and applies when patients did not have mental capacity to make informed decisions. Where necessary patients had been assessed to determine their ability prior to best interest decisions being made. Staff we spoke with had an awareness of the Mental Capacity Act. The practice manager told us they would make arrangement for all staff to receive training.

The trainee nurse practitioner told us they explained tests and treatments to patients before carrying them out and on-going information was provided during the procedures so that patients knew what to expect.

Patient/carer support to cope emotionally with care and treatment

We saw a number of leaflets in the waiting areas for patients to pick up and take away with them. They informed patients of various support groups and their contact details. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We saw a poster in the waiting area that informed carer's of a meeting that was due to be held on 28 November 2014.

Following bereavement the respective GP would contact the family by phone to offer them information about the various bereavement counselling services available to them.

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. Practice staff also demonstrated they identified and provided the necessary services for patients who had complex illnesses such as; district Macmillan nurses.

We found that patients with learning disabilities or mental health conditions were offered an annual health review. Patients aged 85 and over were also offered annual health checks. We saw a poster on display in the waiting area and on the door to the trainee nurse practitioners room advising patients aged 40 to 74 years of age that they could request a health check.

Patients requiring specialist investigation or treatment were referred to hospitals. Patients we spoke with told us they had been given choices about where they wished to be referred to. Patients told us their referrals had been carried out effectively and promptly. There was also a 'choose and book' system so that patients could review the waiting times at various hospitals before making their decisions about where they wanted to be seen.

Older patients and those who were not able to access the practice were able to request home visits. We found that these were carried out the same day they had been requested. Practice staff had organised care provision by community professionals such as district nurses.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. People who were not registered at the practice were seen and treated as temporary patients.

When patients whose first language was not English requested an appointment reception staff automatically gave them a double appointment and arranged for a telephone interpreter service. This enabled effective communications and facilitated patients in understanding their health needs.

At Shipdham Surgery there was easy access for patients with restricted mobility. There were accessible toilet facilities and corridors were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor. The practice had recently had an increase of 335 patients and the proposed house building initiatives in the area was having a significant impact on the ability of the premises to cope with these increases. There was a limited number of consulting rooms and we saw these were being used by various staff to hold clinic sessions with patients. The premises were being used to full capacity.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights and about how they were treated by staff.

Access to the service

Appointments were available each weekday mornings and afternoons. Patients could make appointments from 8am to enable patients such as children to attend before school hours commenced. We asked patients if they were able to access the practice when they needed to. They told us they were satisfied with the opening hours of the practice.

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

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who

Good

Are services responsive to people's needs?

(for example, to feedback?)

handled all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to and there were separate leaflets about complaints available at the reception desk.

The practice staff had a system in place for handling concerns and complaints. We were shown a summary of the complaints received during the last 12 months. We saw they had been investigated, responded to and there were instances where changes had been made to prevent recurrences. Practice staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings.

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. It was evident that senior staff had continued to search for further areas of improvement on an on-going basis. For example, senior staff had developed a positive relationship with the Patient Participation Group (PPG). The members of the PPG we spoke with told us that they had started to communicate with patients and to give feedback to senior staff about patient's opinions about the service they received. The practice manager told us they were planning to conduct a patient survey during the summer of 2015.

The practice manager told us about the efforts they had made towards obtaining funding to increase the size of the premises to accommodate the increasing number of patients. The senior GP was also active in attempting to achieve appropriate premises for patients to visit.

We spoke with 11 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they were encouraged to make suggestions that led to improved systems and patient care.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively. There were specific identified lead roles for areas such as prescribing and safeguarding. Responsibilities were shared among GPs, nurses and the practice manager.

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

The trainee nurse practitioner told us about the support arrangements they had through their Royal College of Nursing (RCN) membership.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly. 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.

At the time of our inspection the provider was not subject to any external peer reviews such as Urgent Health UK (UHUK).

Practice seeks and acts on feedback from users, public and staff

The staff we spoke with told us they felt able to express their views to the practice manager and that any suggestions they had for improving the service would be taken seriously.

The Patient Participation Group (PPG) had recently been established and their first meeting held with senior staff from the practice on 7 October 2014. The aim of the PPG is to ensure that patients and their representatives were involved with decisions about the range and quality of the services provided to them. The PPG had identified that the premises were working to full capacity and were working with senior practice staff in improving the size of the building.

Management lead through learning & improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at a range of staff files and saw that regular appraisals took place which included a personal development plan. We saw that some appraisals were overdue but that dates had been booked for these to take place. Staff told us that the practice was very supportive of training such as the trainee nurse practitioner was arranging to attend some study days concerning infection control to enable them to carry out their lead role in this area effectively.

The practice had completed reviews of significant events and other incidents and shared them with staff via meetings to ensure the practice improved outcomes for patients. For example, a care home manager had identified

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a problem concerning a patient who was receiving warfarin treatment. The senior partner responded by developing a written protocol. After consulting with all staff involved the protocol was implemented to prevent similar occurrences.

We saw that any serious dispensing errors were treated as significant events and fully investigated. If necessary improvement actions were taken and the information cascaded to relevant staff.