Regency 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.

Summary of findings

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Summary of findings

Overall summary

Regency Surgery provides primary medical services from Monday to Friday for patients living in central Brighton. The practice is open from 8.30am until 6.30pm Monday to Friday. On Tuesdays the practice remains open until 7pm to accommodate those patients who work. Due to patient feedback the practice remains open during the lunch period. At the time of the inspection the practice had a patient list of just over 4,000.

On the day of the inspection we spoke with 14 patients, five administrative staff members and three members of clinical staff. This included the two GP partners, the practice nurse and the practice manager. We gained the views of the virtual patient participation group (PPG) via e-mail and asked patients for their views through comment cards left at the practice.

Patients we spoke with were complimentary about the service they received and told us they were able to access the service when needed. They described how they felt respected, cared for and were given appropriate information. We saw the results of a recent patient survey which showed patients were pleased with the service they received and would recommend the practice to family and friends.

We saw the practice had links with other healthcare services. For example, we saw links to the mental health service, who provided counsellors to the practice three times a week.

We toured the practice and found the non-clinical and clinical rooms to be clean, tidy and free from clutter. A member of the clinical team was the appointed infection control lead and was responsible for overseeing infection control at the practice. We saw evidence of an infection control audit completed in May 2014.

Staff told us that they found the leadership team approachable and there was an open door culture. We saw that the practice regularly reviewed staff performance at formal annual appraisal meetings. There were regular meetings within the practice where staff were able to voice their views.

We noted that mandatory training for staff was out of date. However this had been recognised by the practice and plans had been put into place to ensure that all staff were able to complete training necessary for their role before the end of the year.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The service was safe.

We found the practice had systems in place to record and investigate incidents. Staff took appropriate action when receiving medical alerts to ensure patients were protected from known harm. The practice had a safeguarding lead and there were systems in place to safeguard children and vulnerable adults from the risk of harm. Chaperoning posters were visible throughout the practice, which ensured patients could request a member of staff for support while receiving intimate examinations. The practice had up to date emergency medicines and equipment which were easily accessible. The practice had produced an emergency contingency plan. This illustrated how the practice would continue to provide care for patients in the event of an emergency. For example, in the event of power loss to the building. The practice had an infection control lead. The practice was visibly clean and the provider had infection control policies and procedures in place.

Are services effective?
The service was effective.

We found care and treatment was delivered in line with recognised practice standards and guidelines. Staff were appropriately qualified. Staff explained the importance of effective communication between patients, staff and working with other services to co-ordinate care to meet patient needs. Patients were made aware of health promotion and staff were pro-active in engaging patients with health screening. For example, cervical cancer screening.

Are services caring?
The service was caring.

Patients spoke highly of the practice and its staff. They told us they thought the practice was kind, caring and compassionate. They were given adequate time with GPs and nurses and were treated with respect. We observed staff speaking with patients in a considerate and respectful way. Staff told us they thought the practice was able to provide a friendly personal service to patients. They told us patients were seen as individuals rather than a patient presenting with a concern or issue. Staff were able to explain ways to maintain patient confidentiality.

Summary of findings

Are services responsive to people's needs?

The service was responsive to people's needs

Patients were able to access appointment in a number of ways. Appointments could be booked on-line or on the day via telephone. Emergency appointments were available each day. Patients told us they were always able to get an appointment when required. The practice was accessible to those with limited mobility. The practice was aware of the demographic make-up of its patients and tried to plan services in relation to this. For example, by opening late one night a week for those patients who could find it difficult to attend earlier due to work commitments. We saw there was a complaints procedure available to patients and complaints were investigated fully. The practice had access to translation services when needed. The practice had a virtual patient participation group (PPG). This means that the group communicated by e-mail and did not attend meetings in person. Most of the patients we spoke with were unaware of this group. However, we saw on display in the waiting room information regarding the patient participation group (PPG).

Are services well-led?

The service was well-led

Staff understood their roles and it was evident they strove to provide a high level of service to patients. Staff knew who to contact as the lead for different areas within the practice. For example, safeguarding vulnerable adults or infection control. We saw evidence that team meetings were held on a regular basis. We viewed minutes which documented the cascade of information, discussions on improving the service and risks or concerns. Staff we spoke with told us they felt able to raise any issues and these would be taken seriously by the leadership team. We saw evidence of the practice acting on feedback from its patients. We saw information on the practice website and at the surgery to encourage patients to take part in the patient participation group or make a comment about the services provided.

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

The practice was responsive to the needs of older patients. Older patients were cared for as part of the practice's patient centred approach which focused on an individual's needs and preferences. There were specialist clinics and information available to support patients with maintaining a healthy lifestyle. Clinics and advice included diabetic reviews, blood tests and blood pressure monitoring.

GPs could visit older patients at home if they were unable to attend the practice or have telephone consultations.

People with long-term conditions

The practice had arrangements to care for people with on-going health problems. There were appropriate links with community nurses and palliative care teams. The practice regularly met with community nurses and palliative care teams to plan coordinate and deliver effective palliative care.

The practice had clinics to manage patients with chronic obstructive pulmonary disease (COPD), asthma, heart disease prevention and diabetes.

Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Mothers, babies, children and young people

The practice had a named GP lead for safeguarding concerns regarding children. Practice staff had received training relevant to their role. Staff were required to read the practice's safeguarding policies and procedures and we saw these were readily available. Staff were able to demonstrate what would constitute a safeguarding issue and who to report this to. We saw information regarding the local authority's safeguarding procedures were visible to staff to view.

The practice held child health clinics, and made checks on new babies and provided an immunisation programme.

The working-age population and those recently retired

The practice offered late evening appointments one day a week so working age population and those recently retired, had access to flexible appointments. Appointments were also available one lunch time a week. Appointments could be booked on line and patients

were able to request a GP to call them instead of attending the practice. Patients were also able to use the on-line repeat prescription service. The practice remained open during the lunch period for patients to make appointments or receive test results.

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

The practice provided relevant care to patients in vulnerable circumstances who may have poor access to primary care. The practice held multi-disciplinary meetings where 'forgotten patients' were discussed. 'Forgotten patients' were described as patients who had come to the practice with medical concerns but had not contacted the practice for a while. This ensured that patients who may be classed as vulnerable or had poor access to primary health care could be contacted to ensure their on-going health needs were addressed.

We noted that translation services were available for patients who did not use English as a first language.

People experiencing poor mental health

The practice had established links with the community mental health team. This team was present at the practice three times a week. We saw literature available to patients in the waiting room for links with community services and support organisations. There was further information and links to other support organisations on the practice website.

Summary of findings

What people who use the service say

Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. Only one comment card had been completed by a patient. The comments were very positive about the service that person had received.

We spoke with 15 patients on the day of the inspection. All of their comments were positive regarding the care they received by staff. They told us that they had no problems with booking or accessing appointments and found the practice to be understanding of their needs.

Patients told us staff remembered them and they felt safe when discussing their health concerns. They were also given time to ask questions and felt their dignity and privacy was respected.

We reviewed the results of the patient survey, completed in March 2014. 104 patients gave their views on the practice. The survey showed that 92% of patients would be likely or very likely to recommend the practice to friends and family.

Areas for improvement

Action the service COULD take to improve

- Ensure that only staff responsible for medicines can access the medicine cupboard by safely securing the key used.
- Ensure staff are aware of the whistleblowing policy and its meaning
- Ensure patient privacy and dignity are respected in one of the clinical rooms by providing a screen for the couch
- Ensure staff are able to complete mandatory training through having dedicated/protected time
- Ensure patient participation group members are aware of their role in supporting the practice and patients to improve its effectiveness
- Ensure cleaning audits are scheduled at regular intervals
- Ensure the recruitment policy contains all requirements from schedule 3 of the Health and Social Care Act 2008
- Ensure there is a Mental Capacity Act 2005 policy, which staff have read and understood

Regency Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission Lead Inspector and a GP specialist advisor. The team included a second Care Quality Commission inspector and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Regency Surgery

Regency Surgery provides primary care for people living in the centre of Brighton. It currently holds a patient list of 4,000 patients. Patients are supported by a number of GPs, nurses, a practice manager and a team of reception and administration staff. The practice is within the area covered by the Brighton and Hove Clinical Commissioning Group.

The practice premises are situated in a conservation area of Brighton and is not custom built. The practice is able to accommodate those patients with restricted mobility by using ground floor clinical rooms and has two toilets available for disabled patients. Both toilets contained grab rails for those with restricted mobility and one contains baby changing facilities. There is a ramp into the premises for those patients who are in wheelchairs and for parents with prams or buggies. On the ground floor is the reception area, a waiting room and staff area for administration staff, including the practice manager. There are two clinical rooms on the ground floor and two on the first floor. On the first floor there are rooms available for staff including a meeting room, kitchen and staff toilets. Due to the building being listed the provider is unable to make alterations to the building. For example, to add a lift.

Why we carried out this inspection

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

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 patients and what good care looks like for them. The population groups are:

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

Detailed findings

Before visiting, we reviewed a range of information we hold about the practice. We also asked other organisations, such as local Healthwatch, NHS England and the clinical commissioning group, to share what they knew about the practice. We reviewed information that had been provided by the provider and looked at the practice's policies, procedures and some audits.

We carried out an announced visit on 27 May 2014.

We interviewed the Practice Manager, two GPs, a Practice Nurse and administration staff. We also spoke with patients who used the service on the day of the inspection.

Are services safe?

Summary of findings

The service was safe.

We found the practice had systems in place to record and investigate incidents. Staff took appropriate action when receiving medical alerts to ensure patients were protected from known harm.

The practice had a safeguarding lead and there were systems in place to safeguard children and vulnerable adults from the risk of harm. Chaperoning posters were visible throughout the practice, which ensured patients could request a member of staff for support while receiving intimate examinations. The practice had up to date emergency medicines and equipment which were easily accessible. The practice had produced an emergency contingency plan. This illustrated how the practice would continue to provide care for patients in the event of an emergency. For example, in the event of power loss to the building. The practice had an infection control lead. The practice was visibly clean and the provider had infection control policies and procedures in place

Our findings

Safe patient care

Staff informed us there were formal reporting procedures for reporting of incidents or accidents within the practice. Staff were able to describe the process they needed to follow. Staff also told us they would not hesitate to approach the leadership team if they had any concerns.

Most reception staff had worked at the practice for over 10 years and knew the patients well. They told us that if they had any concerns regarding patients when they booked in, they ensured that the GP was informed.

The practice offered patients the services of a chaperone during examinations. A chaperone's main role is to provide reassurance and support for a patient undergoing a procedure they may find embarrassing or uncomfortable. Chaperones may also be used during examinations of vulnerable adults and children. A chaperone could also be requested by the GP. Details of the chaperone service was on display for patients.

Learning from incidents

Staff told us they had regular meetings where incidents could be discussed. Staff were encouraged to give feedback and the leadership team informed us that they checked staff understanding and implications of any near misses. Staff told us they felt there was an open culture within the practice and there was a constant dialogue with feedback from both patients and staff.

We were able to review a recent incident within the practice. A patient had been misidentified due to having the same name as another patient. We saw this had been discussed at a team meeting and measures had been put in place to minimise the risk of the incident recurring. We saw the main action was for staff to ensure dates of birth were requested each time there was contact with a patient. Staff spoken with were able to tell us the new actions they were taking to ensure the incident was not repeated.

Safeguarding

One of the GPs was the safeguarding lead and all staff were aware of who to speak with if they had any concerns. We reviewed the practice's policy on safeguarding and staff were aware of its contents. We saw throughout the practice notices advising staff of actions to take and the names and contact numbers of the relevant bodies should they need to raise a safeguarding alert. This meant that in the event of

the lead not being available, staff would be able to access the correct contact names and numbers for the Local Authority and any other relevant body to report a safeguarding concern.

The practice had also displayed safeguarding information in the waiting room area. Therefore patients, carers and family members had access to information on what may indicate abuse and how to respond to a suspicion of abuse.

We saw evidence that cascade training on safeguarding had taken place in March 2014. The safeguarding lead had attended external training enabling them to provide safeguarding awareness to other staff. We saw minutes from the meeting in March 2014 when this training had been delivered.

The practice had policies on patient confidentiality, consent, complaints and chaperones which were available for staff and patients to review. The practice also had a whistleblowing policy. Whistleblowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk (for example, to patient safety), wrongdoing or illegality. Staff we spoke with were aware of the whistleblowing policy but provided mixed responses as to what it was. Therefore, staff may not fully understand how they would be protected by law if they raised a genuine concern. However, all staff told us they had no concerns with raising issues and were confident that any concerns would be taken seriously by the leadership team.

Monitoring safety and responding to risk

Systems were in place to act upon safety alerts from national bodies. For example, alerts received from the clinical commissioning group relating to withdrawal of medicines or change of dosage were immediately sent to all GPs. Patients taking the medicines in question were alerted and a discussion would be held on the changes in their medication.

We saw that fire safety checks were carried out. Equipment used within the practice was regularly maintained and serviced. We saw evidence that electrical equipment was tested yearly.

Medicines management

Staff were able to describe the process for the ordering of repeat prescriptions. Requests needed to be in writing and would not be accepted over the phone. All prescriptions were signed by GPs and any medicine requests that were unusual or not straight forward would always be reviewed by the GP first. We reviewed the repeat prescribing policy which also contained a repeat prescribing flowchart.

We saw that vaccines were stored within the fridge as these medicines need to be stored at required temperatures. The practice nurse informed us they monitored the fridge temperature on a regular basis and we saw records that confirmed this. We were also informed that there was an agreement with the practice next door to use their fridge in an emergency. Medicines were stored in a locked cabinet. However, the key was on a hook within the same room that could be accessed by staff who knew the code to the door. We spoke with the practice manager regarding this. They informed us they would ensure the key would be locked away, so that dedicated staff could only access it.

Cleanliness and infection control

We spoke with patients regarding the cleanliness of the practice. All told us they had no concerns and thought the practice was kept clean and tidy.

Effective systems were in place to reduce the risk and spread of infection. We were able to spend time with the Infection Control lead who explained the process to ensure the surgeries were clean and hygienic. The lead had conducted an infection control audit in May 2014. We reviewed the audit and found no areas of serious concern had been found. We spoke with the practice manager regarding the findings of the audit. The practice manager was in the process of reviewing the document. Any comments or suggestions that the lead had recommended would be reviewed and an action plan created if needed.

We viewed the practice and found clinical rooms were clean, tidy and free from clutter. We noticed guides above hand washing sinks showing effective hand washing techniques for both staff and patients to view. There were dedicated hand wash basins, which contained liquid soap and paper towels. We noted that alcohol gel was available in clinical rooms and the reception area.

There were arrangements in place for the safe disposal of clinical waste and sharps. Before collection clinical waste was stored in a locked bin away from patients. We saw paperwork regarding the regular collection of waste. We also reviewed the cleaning schedule which was followed by the cleaner and then audited by the practice.

Are services safe?

We reviewed the policies regarding clinical waste and infection control. Policies contained information regarding spillage of biological substances, handling samples, needle-stick injuries and the Control of Substances Hazardous to Health (COSHH)

Staffing and recruitment

We spoke with the practice manager regarding recruitment. The practice had not recruited any new members of staff since 2011. Most staff members had been with the practice for a number of years and there was a low turnover of staff. The practice manager informed us the recruitment policy was in the process of being reviewed. They told us the policy contained recruitment information as required from the Health and Social Care Act 2008 Schedule 3. For example, requesting a full employment history with a satisfactory written explanation of gaps in employment.

We asked staff if they felt there was an adequate number of suitably skilled and qualified staff employed. They told us they had busy periods where another member of administrative staff would be useful. Staff covered each other during holidays and unexpected sickness. We spoke with the practice manager who was aware of pressures on staff during periods of staff absence. We were told that a member of administrative staff would be leaving the practice in a few months. The leadership team were reviewing the job role to be advertised in order to support the practice more effectively.

Dealing with Emergencies

We spoke with the practice nurse who was responsible for ensuring that emergency medicines and oxygen were in date and working correctly. We saw all items including medicines were within the expiry date and regular equipment checks were undertaken.

The practice had a contingency plan in case of emergencies. This documented what the practice would do in certain situations that might affect patient care. For example, if they were unable to use the building or had loss of power. It also contained details of what the practice would do if there was a major incident or during a flu pandemic.

Equipment

We spoke with the practice manager regarding equipment used with in the practice. They were able to show us records of electrical equipment being tested to ensure that it was safe to use. We also saw records that showed fire equipment was regularly maintained and serviced. The GPs were responsible for their own equipment within the clinical rooms and these were maintained regularly.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

We found care and treatment was delivered in line with recognised practice standards and guidelines. Staff were appropriately qualified. Staff explained the importance of effective communication between patients, staff and working with other services to co-ordinate care to meet patient needs. Patients were made aware of health promotion and staff were pro-active in engaging patients with health screening. For example, cervical cancer screening.

Our findings

Promoting best practice

We found care and treatment was delivered in line with recognised practice standards and guidelines. For example, we spoke with a practice nurse who told us they used National Institute for Health and Care Excellence (NICE) guidelines.

The practice had protocols in place when referring patients. For example, referrals were made within 24 hours of the initial appointment for patients with suspected cancer; which was in line with the National Institute for Health and Care Excellence (NICE) recommendations.

The practice did not have a Mental Capacity Act 2005 (MCA) policy. However, staff were able to describe the principals of the Mental Capacity Act 2005 (MCA) and used set questions to conduct an appropriate assessment. The GPs also explained how if patients were unable to consent to care or treatment, how decisions were made in the 'best interest' of the patient.

Management, monitoring and improving outcomes for people

The practice manager told us there were regular multidisciplinary meetings attended by the Integrated Primary Care Team and the Palliative Care team. We were informed these meeting discussed patients who needed extra support or acute care. For example, those patients who were suffering from cancer. We saw evidence of this through minutes to meetings held. The manager explained the meetings also discussed 'forgotten patients' meaning patients who had come to the practice with medical concerns but had not contacted the practice for a while. Or if friends or family members raised concerns with the practice these patients could also be discussed.

Staffing

We spoke with staff regarding their annual appraisals. We were able to see evidence that staff were given an annual appraisal and were given opportunities to discuss issues or training requirements. We were informed that staff did not receive formal supervision but instead the practice had an open door policy. Staff we spoke with told us they had no concerns with speaking with the leadership team and felt that communication between all team members was very good.

Are services effective?

(for example, treatment is effective)

After talking with staff we noted there were concerns with staff having time to access training. We spoke with the practice manager regarding this. They explained that due to some staff having part time roles it was difficult to organise team training where everyone was able to attend. They informed us they had asked staff this year to undertake computer based training which would avoid the need to attend team training sessions. After the inspection the practice manager submitted a spread sheet of training that staff had completed and still needed to attend. Each staff member had received information regarding their outstanding training requirements and given dates when this needed to be completed by. We also saw the practice was planning to use Protected Learning Sessions for staff to access the on-line training.

Working with other services

We spoke with staff regarding arrangements with working with other services. Staff were able to give examples of working relationships with drug and alcohol services and mental health services. We were informed that counsellors from the 'Well Being' mental health service ran three sessions weekly from the practice for patients to attend.

The practice had working agreements with the larger practice situated next door. This included using their equipment in the case of an emergency or break down. For example, use of the fridge for the storing of vaccines if the Regency fridge was to breakdown. The practice nurse also linked in with the nurses at the other practice for support.

Health, promotion and prevention

We viewed the waiting room area. We saw there were leaflets and posters promoting different services and advice for patients. For example, on display was a variety of medical health conditions leaflets that patients could take away to read. Carers and support services for vulnerable groups were also advertised in the waiting room.

We spoke with staff regarding the promotion on smoking cessations. Although staff were promoting this service they knew that the engagement rate was relatively low. They were able to explain a number of reasons why that might be the case.

We spoke with the practice nurse. They explained how they managed patients with long term conditions. For example, diabetics and asthma. Part of managing these patients was to ensure that patients received healthy living advice. This included things such as healthy eating and exercise. They also explained they were pro-active in increasing breast and cervical cancer screening uptake.

Are services caring?

Summary of findings

The service was caring.

Patients spoke highly of the practice and its staff. They told us they thought the practice was kind, caring and compassionate. They were given adequate time with GPs and nurses and were treated with respect.

We observed staff speaking with patients in a considerate and respectful way. Staff told us they thought the practice was able to provide a friendly personal service to patients. They told us patients were seen as individuals rather than a patient presenting with a concern or issue. Staff were able to explain ways to maintains patient confidentiality.

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with told us they felt all staff at Regency Surgery treated them with dignity and respect. They also told us they felt their privacy was respected and personal information was never asked for when booking in at reception. We received several comments from patients as feeling looked after 'personally', 'well cared for' and feeling 'safe' when discussing health needs.

We observed staff in the reception area. Staff were seen to be polite and friendly, and knew most patients by greeting them by their names. Staff gave us examples of how patients were respected. This included using a private room if patients wanted to speak in confidence and keeping patients informed if the GPs appointment' slots were over running.

Staff informed us they were aware of the importance of patient confidentiality and felt it was taken very seriously within the practice. Staff told us they signed a confidentiality agreement and were able to explain the practical things they did. For example, they ensured that computer screens could not be seen by patients and patients were never discussed in the reception area, where there may be the possibility of being over heard. The practice had a confidentiality policy.

We noted appointments took place behind closed doors. Clinical rooms contained screens around the consulting couch for examinations, which offered protection for patient's privacy and dignity. However, we found one clinical room did not contain a screen around the consulting couch. We spoke with the practice manager regarding this. We were informed the room had originally been for administration staff and had only just started to be used by a GP. We were told the GP stood in a separate enclosed area of the room while patients got ready for an examination. They informed us they would order a screen as they recognised that patients may require more privacy.

Involvement in decisions and consent

Patients we spoke with told us they felt involved in their care and were given information to ensure they could decide the best treatment for them. They told us they were able to ask questions and when necessary were given extended appointments to cover all of the information necessary. One patient told us the GP had given them

Are services caring?

further information after undertaking further research on their condition. Another patient informed us they had declined when requested if a student GP could sit in with the consultation. The patient told us the GP had respected their decision to see them alone to maintain their privacy. Several patients we spoke with told us they had been given healthy living advice to help manage their conditions.

GPs and nurses told us the practice had a patient centred approach and all patients were asked for verbal consent before making decisions regarding their care or treatment. Both the GPs we spoke with described how they would conduct a 'best interest' meeting for those people who lacked the capacity to make their own decisions. These meetings included people who knew and understood the patient or had legal powers to act on their behalf.

The GPs explained several ways in which they ensured patients understood as fully as possible their condition or options available to them. This included booking follow-up appointments or calling the patient after the initial consultation. One patient told us the GP had unexpectedly called to check how they were, which they thought was very caring.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs

Patients were able to access appointment in a number of ways. Appointments could be booked on-line or on the day via telephone. Emergency appointments were available each day. Patients told us they were always able to get an appointment when required. The practice was accessible to those with limited mobility. The practice was aware of the demographic make-up of its patients and tried to plan services in relation to this. For example, by opening late one night a week for those patients who could find it difficult to attend earlier due to work commitments. We saw there was a complaints procedure available to patients and complaints were investigated fully. The practice had access to translation services when needed. The practice had a virtual patient participation group (PPG). This means that the group communicated by e-mail and did not attend meetings in person. Most of the patients we spoke with were unaware of this group. However, we saw on display in the waiting room information regarding the patient participation group (PPG).

Our findings

Responding to and meeting people's needs

Regency Surgery had two male GPs. To ensure that female patients could request to see the same sex GP, a female GP worked one day a week. The practice recognised that one day may not be adequate but had not received any concerns from patients. However, one patient did inform us that they would prefer to see the female GP and was unhappy with discussing their condition with the male GP. We also saw the female GP extended her appointments through the lunch time period to ensure patients that worked could attend appointments.

We asked staff about those patients who accessed the service but whose first language was not English. We were told the practice had access to a translation service and some patients would bring in family members to translate. GPs and nurses were aware when to use a translator in situations where a family member may not be appropriate and would request a further appointment when this could be arranged.

The practice had a virtual patient participation group (PPG). PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs. By being virtual the group did not attend meetings but were contacted via e-mail and were sent information to review and respond to. Members of the group were also forwarded information on city-wide PPG events and newsletters. The group was made up on 20 patients. The practice manager informed us that although information was sent to the PPG, responses back were quite limited. We e-mailed one member of the group who informed us they felt the group had helped to establish lunch time openings. However, they were unaware of other responsibilities the group held.

Access to the service

Patients we spoke with told us they were always able to get appointments when needed. They were happy with the practice opening times and could always access emergency appointments if needed.

We saw that patients could make appointments in a number of ways. They were able to call the practice, come in directly or use the on-line facility to request an appointment. The practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice and on the practice's website and practice leaflet.

Are services responsive to people's needs?

(for example, to feedback?)

We noted there was one late evening appointment a week and the practice did not close at lunch times. Patients were able to ring and make appointments, get test results or request prescriptions throughout the day.

Patients were also able to request to speak to the GP or nurse via the telephone. We noted telephone consultation times were clearly displayed on the website. The practice could also arrange home visits when requested or necessary.

The practice could accommodate those patients with restricted mobility or who used a wheelchair. We saw there was a ramp in to the building and doors were wide enough for wheelchair access. The waiting room contained a number of chairs for patients but also contained space for those with prams or pushchairs. We noted the two patient toilets were easily accessible for those patients who used wheelchairs and one toilet contained baby changing facilities.

Concerns and complaints

Patients we spoke with told us they had never needed to make a complaint but would be happy to speak with staff and thought their concerns would be listened to.

Regency Surgery had an effective complaints policy and procedure. Staff we spoke with were aware of the policy and how to respond.

The practice manager explained that where possible, the complainant would be spoken to face to face to discuss their concern. If the complaint could not be resolved, the patient would be asked to make the complaint in writing and would be acknowledged by the practice within three working days. The complaint would then be investigated and the complainant kept updated. If the complainant was unhappy with the outcome they would be advised to take this further and directed to write to the Health Service Ombudsman.

The practice had received three complaints within the last year. We reviewed one complaint and saw the practice had followed its policy and responded in the correct times frames. Although the complaint was on file, the response from the GP had not been copied over from the patient's medical notes. The practice manager did not have full details of the complaint in one file and may have been unaware if the complaint had been dealt with in-line with the practice's policy.

Staff told us that complaints or concerns were discussed at team meetings and through informal meetings or one to ones.

Are services well-led?

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

Summary of findings

The service was well-led

Staff understood their roles and it was evident they strove to provide a high level of service to patients. Staff knew who to contact as the lead for different areas within the practice. For example, safeguarding vulnerable adults or infection control. We saw evidence that team meetings were held on a regular basis. We viewed minutes which documented the cascade of information, discussions on improving the service and risks or concerns. Staff we spoke with told us they felt able to raise any issues and these would be taken seriously by the leadership team. We saw evidence of the practice acting on feedback from its patients. We saw information on the practice website and at the surgery to encourage patients to take part in the patient participation group or make a comment about the services provided.

Our findings

Leadership and culture

It was clear when talking to staff that they took pride in their roles within the practice and strived to ensure that patients experienced the best possible care.

Staff we spoke with told us there was an open, no-blame culture. The focus was on communication and staff being able to have open discussions when needed. There had been recent changes to the GP partnership and a new practice manager was in post. This had meant changes within the practice but most staff thought these changes had been for the better.

Staff were clear on the management structure within the practice. The practice manager had overall responsibility for the day to day functioning of the practice. In addition to their clinical roles the practice nurse was the infection control lead and a GP was the nominated safeguarding lead.

Administrative staff were aware of other staff roles and when needed were prepared to help each other out. We were given examples of staff taking on extra work when the medical secretary took leave to ensure the practice worked smoothly. Staff told us they felt supported and valued by their peers.

Governance arrangements

The practice had a range of meetings that took place within the practice. This enabled staff to keep up to date with practice developments and ensured that there was good communication between the GPs and the administration team. Significant events and complaints were discussed to ensure staff learnt from them. Actions were minuted as to how to avoid similar incidents in the future.

We saw that staff took on specific leads within the practice. For example, safeguarding and infection control. Staff we spoke with were aware of which staff were responsible for which area.

The practice had a range of comprehensive policies and procedures covering a variety of topics. For example clinical waste, equality and diversity and complaints handling.

Systems to monitor and improve quality and improvement

The practice undertook several audits and used the Quality and Outcomes Framework (QOF) to monitor the service

Are services well-led?

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

being provided. Quality and Outcomes Framework (QOF) is a voluntary programme for all GP surgeries in England that detail the practices achievements. This is then financially rewarded annually.

The practice was in the process of changing their computer system which would allow a greater ease of producing audits. Staff we spoke with, told us of a recent audit which had been completed for those patients receiving specific medicines. Safety measures had been put in to place for those patients due to a local incident. Another example was given of the practice recognising that previously they had prescribed a high rate of a particular medicine. The practice had worked to bring the prescribing rate down and we saw data that evidenced this.

All incidents, accidents and safety alerts were discussed and actioned when necessary. Minutes we reviewed of team meetings recorded evidence of this. This ensured that patients safety was discussed and when necessary appropriate action taken.

Patient experience and involvement

The practice had actively sought the views of patients. We saw information on the practice website and at the surgery to encourage patients to take part in the patient participation group or make a comment about the services provided. For example, we noted in the toilets that had been adapted for patients with a disability, there were two soap dispensers at differing heights. The practice manager informed us they had received informal feedback from a patient who used a wheelchair. They had explained that the height of the soap dispenser meant it was not assessable. The practice had responded to this and installed a second dispenser at a lower level. This also meant children were able to use this as well.

We viewed a patient survey which had been completed in March 2014. The practice had a total of 104 respondents. Results from the survey indicated that patients thought highly about the practice and 92% would be likely or very likely to recommend the practice to friends and family. We saw the results were published on the practice's website and were on display in the waiting room area. An action plan had been created on some of the points raised and these were discussed with the PPG.

The patient survey had received a small amount of comments about the practice re-installing a television screen which gave various health information for patients in the waiting room. Comments had been negative about having this re-installed. The practice had recognised that further engagement with their patients was needed before a decision could be made and was therefore actively seeking the view of its patients

Staff engagement and involvement

Staff told us there were regular meetings they attended. This included a meeting for administrative staff and a separate meeting for the leadership team. We were able to see minutes for both meetings and saw information was cascaded from one meeting to the other. All staff we spoke with told us they would be happy to speak out at these meetings and felt this was encouraged. A nurse informed us one of the GPs was arranging regular clinical reflective sessions, which they thought would be very useful.

Staff were given annual appraisals which enabled them to discuss their role and any future plans for themselves or the practice.

Learning and improvement

The practice used the comments received from the patient survey to help improve the practice. For example, the practice currently had made lunch time appointments available one day a week. As this was proving popular they were looking to see if this could be increased. We saw that an action plan had been produced from the results and was available for patients to see

We were also informed the practice was considering installing a patient booking in screen within the reception area. The practice manager informed us it was thought this would help to eliminate patient identifications errors and free up reception staff time. This was planned to be installed after the practice changed their in house computer system.

The practice manager informed us patients regularly gave informal feedback, which was always considered. For example, a patient who was a wheelchair user had commented that the soap dispenser was too high to use. We noted another soap dispenser had been added at a lower height.

Identification and management of risk

We spoke with the medical secretary regarding risks. We were given an example where regular audits were in place to identify and manage potential risks. They explained all referrals to other health bodies were audited in regards to

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patients attending appointments or where appointments were outside of the time frame recommended by clinical guidance. This information was passed to the GPs for further action if required.