Dr Timothy Evans

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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Timothy Evans on 03 December 2014. Overall the practice is rated as Good.

Specifically, we found the practice was good for providing a safe, effective, caring and responsive service. Some improvement was needed however for providing a well led service.

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

- Staff demonstrated a clear understanding of the issues relating to safeguarding vulnerable adults and children.
- The practice was clean and there were suitable infection control arrangements to reduce

the risk of cross infection.

- The GP worked with other healthcare specialists to share good practice and meet patient's needs using an holistic approach to health and wellbeing.
- Patients felt access to the practice was good, with urgent appointments available the same day.
- The practice had numerous ways of identifying patients who needed additional support, and were proactive in offering this.
- The GP showed a sensitive and caring approach towards supporting patients, their family and carers with bereavement.

The areas where the provider should make improvements are:

- Further develop its vision and strategy.
- Further embed the practice policies and procedures to govern activity.
- Encourage patients to use the intranet to give feedback and suggestions to the practice.
- Ensure the practice nurse receives a regular clinical appraisal.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff had received training appropriate to their roles. Staff undertook multidisciplinary working with other health care providers to ensure patients received the treatment and support they needed. Clinical audit cycles had been undertaken to demonstrate improvement.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but this needed to be further developed. We acknowledged that the practice is unique and needed to take in other considerations and discuss with other departments when developing a strategy. The practice had a number of policies and procedures to govern activity, but some of these needed further

Summary of findings

embedding. The practice nurse received regular clinical supervision but should be offered a regular clinical appraisal to support their professional development and offer appropriate feedback on their clinical practice.	

Summary of findings

The six population groups and what we found

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

Older people
There were two patients over the age of 75 registered with the practice. Numbers in this population group of older people were therefore insufficient for CQC to pass comment, so we did not rate it. It must be noted, however, that practice staff demonstrated an awareness of the needs of patients over the age of 75.

Not sufficient evidence to rate

People with long term conditions
The practice is rated as good for the care of people with long-term conditions. 18% of all patients registered with the practice had been identified as having a long term health condition. We were told that patients were involved in their care and we saw evidence of multidisciplinary working and regular reviews of those on long term medication.

Good

Families, children and young people
There were 33 patients registered at the practice in this population group of families, children and young people. The GP showed a good understanding of the needs of children and families. Patients we spoke with said the practice treated children in an age appropriate way and would see children not registered with the practice who were related to registered patients if requested. Counselling and family planning services were available to Royal Household staff and their families.

Good

Working age people (including those recently retired and students)
The practice is rated as good for the care of working-age people. There were 245 patients of working age who made up the majority of registered patients at the practice. These patients were offered an accessible service which all patients we spoke with and received feedback from stated they were very satisfied with. The practice offered a full range of health promotion and screening services which reflected the needs for this age group.

Good

People whose circumstances may make them vulnerable
This population group was not represented in the registered patients at the practice, so we did not rate it.

Not sufficient evidence to rate

People experiencing poor mental health (including people with dementia)
The practice had one patient registered as having poor mental health, therefore numbers in this population group were insufficient

Not sufficient evidence to rate

Summary of findings

for CQC to pass comment, so we did not rate it. It must be noted, however, that practice staff demonstrated an awareness of the needs of patients experiencing poor mental health and had the tools to test for dementia.	

Summary of findings

What people who use the service say

We received 37 completed Care Quality Commission (CQC) patient comment cards and spoke with six patients on the day of our visit. All the comments were very positive about all aspects of their care, with no negative comments recorded.

Patients said the service was patient centred and they never felt rushed. Patients said they always felt they had been listened to and they felt comfortable talking to the doctor about sensitive issues.

Patients we spoke with were positive about the emotional support provided by the practice and said overall the service was excellent and staff were very caring and compassionate.

Areas for improvement

Action the service SHOULD take to improve

- Further develop its vision and strategy.
- Further embed the practice policies and procedures to govern activity.
- Encourage patients to use the intranet to give feedback and suggestions to the practice.
- Ensure the practice nurse receives a regular clinical appraisal.

Dr Timothy Evans

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP special advisor and a CQC inspection manager.

Background to Dr Timothy Evans

Dr Timothy Evans also known as The Royal Mews Surgery is a unique practice which is situated in the grounds of Buckingham Palace which is located in the London Borough of Westminster. It provides a GP and Occupational Health service to residents and employees (including temporary summer employees) of the Royal Household and their families. The practice covers Buckingham Palace, St James' Palace, Clarence House and Kensington Palace. This is the only location operated by this provider.

The practice has a closed register of 288 patients and held a GMS contract with NHS England. The practice staff consisted of one doctor and one practice nurse.

Because of the service it provides and the make-up of its patient group, the practice is unique and cannot be compared with other practices. It does not reflect the patient population of the locality, for example there are no patients registered with learning difficulties, and it has particular security considerations.

The practice provided a NHS GP service for 50% of the time and a private health care service for the other 50%. We inspected the part of the service provided for NHS patients.

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.

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 and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Detailed findings

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We liaised with Westminster Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We undertook a planned, comprehensive inspection on 3 December 2014. During our inspection visit which took place over one day, we spoke with the principle GP and the practice nurse. We also spoke with six patients and received 37 completed Care Quality Commission (CQC) patient comment cards.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. We viewed an up to date risk assessment which covered all relevant areas. We were told that there had not been any safety incidents in the last ten years and consequently there were no records. Staff were however aware of their responsibilities to raise concerns and knew how and who to report incidents and near misses to. The doctor understood the reasons and benefits of the significant event analysis process.

Learning and improvement from safety incidents

As there had been no incidents recorded, there was no record of learning from incidents. There was however a procedure in place to review incidents and implement procedural changes should they arise, this included obtaining patient feedback and analysing recurring problems.

We were told by staff that national patient safety alerts were initially dealt with by the practice nurse who would then discuss these with doctor and action as appropriate.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that both staff members had received training in safeguarding vulnerable adults and level 3 training in safeguarding children.

The practice GP was the clinical lead for safeguarding and was a member of the Child and Vulnerable Adults Safeguarding Committee. Annual meetings were held with the Royal Household to discuss adults and children who were known to be vulnerable. We viewed the procedures for safeguarding and these were appropriate and contained relevant information, for example who to contact to make a referral.

We were told that patients were asked if the wanted a chaperone, and that the nurse would act as chaperone if requested.

Medicines management

We checked medicines stored in the treatment rooms, including those medicines stored in refrigerators. We found all medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, including the action to be taken in the event of a potential power failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. We noted that the practice had written the expiry date on each medicine box, which had then been stored in date order as an additional safety check. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw documentary evidence that following a power cut, all vaccines stored in the refrigerator had been destroyed due to the raised temperate compromising their safety and effectiveness.

We saw documentary evidence of reviews which had been carried out for patients on long term medication.

We were told that the GP took responsibility for the administration of immunisation for babies and the practice nurse took responsibility for the administration of adult vaccinations using directions that had been produced in line with legal requirements and national guidance.

All prescriptions were reviewed and signed by the GP before they were given to the patient.

Prescriptions were dispensed by a local chemist which the practice had regular contact with.

Cleanliness and infection control

We observed the premises to be clean and tidy.

The practice nurse was the appointed infection control lead. We were told that cleaning was carried out by an external cleaning company who operated within agreed schedules. Clinical waste was correctly stored and the practice had a contract with an external company for the disposal of clinical waste.

We viewed the infection control policy which covered all relevant areas. The GP and practice nurse were both able to describe the process for the receiving and disposal of specimens, for example the use of protective gloves.

Good

Are services safe?

The procedure for dealing with needlestick injury was on display with appropriate directions for treatment.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Staff told us that the practice operated under the health and safety policies of the Royal Household and relevant records were held by them. We were told that he management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings) had been undertaken via the facilities department of the Royal Household.

Equipment

Staff we spoke with told us they had 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.

We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer, which was in date.

Staffing and recruitment

We were shown the Disclosure and Barring Service (DBS) check for both members of staff. We noted that both members of staff had been employed at the practice for more than seven years, which predated the recruitment requirements imposed on providers following their initial registration with CQC. We were however assured that both staff members had been through a robust recruitment process as part of their initial employment. We checked the General Medical Council and Nursing and Midwifery Council registers to confirm that both members of staff were qualified and able to practice.

We were told that in the absence of the GP or practice nurse medical support could be provided by other senior members of the Royal Household medical team and that identified locums could be used.

The nurse also covered the duties of practice manager which we were told did present a challenge on their time and there had been no specific training for this role. Assistance had been provided however by a colleague from another practice and we were told that the practice was in the process of recruiting a dedicated practice manager.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

We saw an up to date risk assessment for the surgery which covered all areas of the surgery, appliances and equipment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were also readily available.

We were told that the practice had not had to deal with any emergencies within the last ten years.

We were told that the surgery's disaster plan was part of and overseen by the Royal Household security system. The GP said the first aid centre based in the Royal Household could be used temporarily if the surgery became unsuitable for use, but there would be no access to computer based records.

Emergency medicines were available in a secure area of the practice and staff knew of their location. All the emergency medicines we checked were in date and fit for use.

The practice nurse was also the fire officer and we were told that training for fire marshals was organised via the Royal Household. We were told that the fire equipment was serviced by an external company and fire drills were held every Monday morning at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and practice nurse could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. As there are only two members of staff, we were told that information was discussed on a daily basis.

Because of the practice's particular patient population, the ethos of the practice was to ensure the continuing wellness of patients. Patients were assessed on their individual needs and followed up as appropriate.

The practice was unique in the service it provided to the Royal Household so benchmarking (comparing performance against other practices) was not appropriate as there are no directly comparable practices.

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

The practice provided an effective service and this was confirmed in the comments we received from patients.

Management, monitoring and improving outcomes for people

The practice followed an holistic approach to improve the health of patients and promote wellness.

The practice had a system in place to effectively assess and monitor the quality of patient care and treatment and were able to evidence that audits were used to drive improvement in performance to improve patient outcomes.

We were shown an audit of statins (a medicine prescribed to reduce cholesterol) undertaken in 2013, which had been re-audited in 2014. This audit evidenced that the practice had already identified those patients who were likely to benefit from a statin following the reduced threshold guidance from The National Institute for Health and Care Excellence (NICE).

In addition the practice had undertaken an audit to identify those patients with asymptomatic atrial fibrillation. This was a single cycle audit and was due for a re-audit later in 2015.

The monitoring systems in place were appropriate to the particular needs of the patient population. Due to the very small number of registered patients the practices QOF data had not been declared. (QOF is a voluntary incentive scheme for GP practices in the United Kingdom. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

To ensure that appropriate information was recorded we reviewed the records of 13 patients, these showed appropriate care and clear record keeping.

Effective staffing

The practice staff consisted of one doctor and one practice nurse. The practice nurse also acted as the practice manager and we were told that this could present a challenge due to the amount of paperwork and time spent on other duties such as covering at Palace events. We were also told that time was limited to meet with colleagues outside of the practice to share ideas and good practice. The practice nurse kept up to date with training and current good practice through reading and online research.

Both the members of staff were suitably qualified. The doctor had been revalidated in 2013. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We were told that the practice nurse had been appraised on the non-clinical aspects of their position but there had been no formal appraisal of their clinical practice. We were assured however that the nurse met with the GP every week day and felt able to discuss clinical matters either during this time or through telephone contact.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood test results, X-ray results and letters from the local hospital were received electronically or by post and acted on as appropriate.

Good

Are services effective?

(for example, treatment is effective)

We looked at the GP's pathology results inbox and found no pending or unactioned results.

We were told that the practice attended an annual safeguarding meeting with other members of the Royal Household, but there were no other attended multi-disciplinary meetings for safeguarding.

Staff said they promoted wellness and they proactively worked with other healthcare specialists to meet patient's needs using an holistic approach to health and wellbeing. An osteopathy service operated from the practice once a week and a podiatry service operated from the practice once a month. The practice had close links with many healthcare professionals offering holistic treatment and care where patients could be referred such as counsellors**,** physiotherapists and diet and nutritionists.

Information sharing

The practice mainly used an electronic system to communicate with other providers. Staff were in the process of being trained on the use of a new electronic patient record system, and commented positively about the system's safety and ease of use. Information received in paper form was scanned and added to the system on a daily basis. Staff said they ensured patient confidentiality by only sharing clinically relevant information in referral letters to other services. Some patient records were only held in paper form and access was limited to specific individuals to maintain security and confidentiality.

The practice did not use the 'Choose and Book' system (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital) for referrals for reasons of confidentiality. It did use the two week wait element of Choose and Book to ensure suspected cancer patients were seen by a specialist within two weeks of referral.

The GP recognised that an increased use of clinical coding on patient records could make information sharing quicker and safer in their absence.

Out of hours information was shared via the electronic 'Docman' system (an electronic document management, messaging and workflow solution designed specifically for NHS Trust GP practices and secondary care facilities such as hospitals).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Staff understood the key parts of the legislation and were aware of the need to always consider a patients best interests.

Staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). We were told that the practice had not had to refer to either the Mental Capacity Act or Gillick Competencies in their work.

We viewed the practice's policy on consent to care and treatment which was appropriate. We were told that consent, both verbal and in writing, was recorded on patient records, along with the explanation of the treatment which was given to the patient. We viewed a random section of patient records and saw that consent had been appropriately recorded.

We were told that the practice did not carry out any minor surgery or contraceptive implants.

There were no patients with learning difficulties registered with the practice, and none who lacked capacity, but the doctor demonstrated an awareness to put patients' needs first and an awareness of the tools to diagnose dementia.

Health promotion and prevention

The particular service that this practice provided meant that it did not reflect the same working practices that a practice operating in the representative local population would have done.

We were told that the practice gave advice on smoking cessation and kept a record of those patients who smoked. All smokers had been identified and had been given smoking cessation advice.

The practice also offered childhood immunisations, flu jabs and travel vaccinations. The nurse was trained to give the yellow fever vaccination and undertook the cervical smear testing for women. The practice could confirm that 77% of patients who required a smear test had received one. This was higher than the CCG average. Eighty nine percent of the over 65's and 68% of 18-65 year olds had received a flu vaccination. Processes were in place for shingles and pneumococcal vaccinations. The practice followed up patients who did not attend.

Good

Are services effective?

(for example, treatment is effective)

The GP told us that they had regular meetings with the head chef of the Royal Household with regard to the food provided in the dining room for those registered patients working for the Household.

The practice's information leaflet listed services available to patients, such as family planning, travel advice and counselling services. Health advice was offered to patients via the Royal Household intranet and all employees had access to a gym within the Palace.

New patients completed a medical questionnaire and staff said if any issues were identified such as long term conditions they were offered a medical. We were told that the practice did not offer NHS health checks to those patients aged 40 – 74. Patients were however, contacted by the practice nurse and encouraged to have an annual flu jab and patients between 70 and 79 years of age were offered the shingles vaccination.

As previously stated, it was not appropriate to examine population statistics with regard to this practice as the practice did not reflect the local population groups, but within its particular group of patients health promotion and prevention was appropriate.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Both the doctor and the nurse demonstrated respect, dignity, compassion and empathy in our discussions with them. We were told that due to the small number of patients registered with the practice the access for appointments was very good and staff knew their patients well.

We spoke to six patients and received 37 CQC patient comment cards. None of the patients we spoke with could remember taking part in a patient survey but all were very satisfied with the service, saying they never felt rushed and always felt that the doctor had listened to them. Patient comment cards were also very positive. Patients said the service overall was excellent and staff were very caring and compassionate. They also said the service was patient centred and they felt comfortable talking to the doctor about sensitive issues.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Treatment rooms had a screen which could be pulled around the examination couch and the door could be locked to ensure further privacy. We noted that though doors were closed during consultations, conversations taking place in the GP consultation / treatment room could potentially be overheard. We discussed this with the GP and nurse who did not believe this to be an issue. Both assured us that appointments were staggered to limit patient waiting time and therefore it was very rare that a patient had to sit and wait. Both felt the risk of being overheard and consequently any breech in confidentiality was extremely low.

Care planning and involvement in decisions about care and treatment

We were told that patients with chronic and long term illnesses had plans for their care discussed with them; this was sometimes recorded and documented as a 'care plan'.

Patients who we spoke with said that their treatment was always clearly explained, and that staff always had time to explain treatment procedures and options. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. For example, we were told that a representative of the practice had attended a memorial service and a funeral for patients of the surgery to pay their respects.

The practice leaflet gave patients information on counselling services available to Royal Household staff and their families and an occupational health service was available for all employees.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

We were told that the practice had an holistic approach to patient care, promoting wellness through diet, exercise and lifestyle. The practice offered 'well man' and 'well woman' checks to all patients. This information was available in the practice information leaflet and the last sessions had been undertaken by the practice nurse during June and July 2014. In addition the practice used the Royal Household intranet system to advertise workshops and programmes for life style and wellbeing, such as healthy eating and care of the back in the work place.

The practice did not have a patient participation group (PPG), though details of how to make suggestions or a complaint were set out in the practice information leaflet and the GP said they used the Royal Household intranet for two way communication with patients. Over 50% of patients had made use of the intranet system for communication with the practice. The practice also had a suggestion box in the waiting area which patients were encouraged to use for both complaints and suggestions.

Tackling inequity and promoting equality

The practice had 288 registered patients. All patients registered with the practice were residents or employees of the Royal Household and their families. Consequently the practice was not reflective of the general patient population of the area and did not provide a service to groups such as the homeless, travellers or asylum seekers.

We were told that the practice did see unregistered patients, but only those who were related to patients already registered.

We saw that the practice had in place an equality and diversity policy and no patients we spoke with raised any concerns in the area of equality.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Access to the service was good. The practice was open Monday- Friday from 0800-1700. Appointments with the GP were available from 14.30 – 16.30 on Mondays, Wednesdays and Thursday and 0900 – 11.00 on Tuesdays and Fridays, however outside of these specific appointment times patients requiring an urgent appointment were given one on the same day. We were told by staff and patients that in most cases non urgent appointments were also available on the same day. Home visits were available, but staff said these were very rarely requested. We were told that patients from other sites away from where the surgery was based were brought to the surgery by car if needed. After 1700 during the week, bank holidays and at weekends, the practice leaflet informed patients to contact the duty doctor if they required medical attention. Patients were also advised they could contact the NHS 111 service; access the local NHS walk in clinic or call the emergency services if appropriate.

The practice did not have a website for security reasons, but there was information on the staff intranet and a practice leaflet was available which detailed surgery hours, services available and how to make a suggestion or complaint. This leaflet was also available in large print for those patients with poor eyesight.

There were appropriate arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

All the patients we spoke to were satisfied with the appointments system and very pleased with the service. This was confirmed by the patients comment cards which we received.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations

Good

Are services responsive to people's needs?

(for example, to feedback?)

for GPs in England. We were told that the practice nurse dealt with complaints and the doctor in her absence. The practice had received one complaint four years ago which had been unrelated to any permanent member of staff.

We noted in conversation with the practice nurse that the complaints procedure would be reviewed to include the head of the medical household to avoid any conflicts of interest which may arise due to the very small staff team.

We saw that information was available in the practice waiting area and in the practice leaflet to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice, but confirmed that they would be confident in doing so should they need to.

Are services well-led?

Requires improvement

(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 basic vision and strategy to deliver high quality care and promote good outcomes for patients through holistic care. This had been shared with and was known by the practice nurse.

The practice promoted wellness as part of their strategy. The practice should review and formalise it's vision and strategy, particularly as the staff team was due to expand in the near future.

Governance arrangements

The practice had two members of staff who consulted on a daily basis and had clearly defined roles.

The Quality and Outcomes Framework (QOF) to measure the performance of practices was not a meaningful indicator for this practice due to the small number of patients. The practice acknowledged that it needed to improve its computerised recording of medical terms and we were told that a new electronic system was being installed which would support these improvements.

We were told that the practice did have some issues regarding professional development of staff and isolation due to the difficulty of covering for absences and the uniqueness of the practice. We were told that a practice manager was being recruited and also locum doctors vetted to provide extra staff cover in the absence of the GP.

There was a policy for assessing and monitoring the quality of service provision but there were no records in place to evidence that this had been implemented to further develop the practice. The practice had policies and procedures in place however these new and had not been fully embedded.

The practice had arrangements for identifying, recording and managing risks.

Leadership, openness and transparency

Both staff said they met every day and discussed issues as they arose, however as these discussions were ad hoc there were no records available for inspection.

We were told that the Royal Household was responsible for human resources, produced recruitment/employment policies and procedures, held personnel records and dealt with human resource matters. We were told that the practice nurse had raised concerns about their dual role of practice manager/practice nurse which carried a significant increase in paperwork. The practice had looked at this and as a direct response had begun the recruitment of a part time practice manager.

Seeking and acting on feedback from patients, public and staff

The practice had a policy for assessing and monitoring the quality of service provision which identified patient feedback as a tool for this. The practice had a suggestion box and patients had access to a two way intranet system which enabled them to communicate with the practice. The practice information leaflet contained information on how to make a complaint or suggestion.

The practice nurse told us they felt they could raise issues with the GP, were listened to and we were given an example where additional staff support had been employed as a direct result of concerns raised.

The practice had a whistleblowing policy. A review of this was needed to consider the inclusion of an alternative named person that staff could contact to avoid a conflict of interest which may occur from being a very small staff team.

Management lead through learning and improvement

The nurse told us that they kept up to date with training and current good practice through reading and internet research. We were told that it was sometimes difficult to make the time to spend on professional development due to the work load. The GP told us that this had been addressed through the recruitment of an experienced practice manager who was due to commence employment on 1 April 2015.

The practice nurse had undertaken training in automatic external defibrillator, basic life support and manual handling in the 12 months preceding the inspection visit.

The GP said they met with the practice nurse and the relief nurse on a regular basis to discuss clinical issues.

We were told that the nurse was appraised for the administrative part of her role. Although the nurse did not receive a regular clinical appraisal, they did meet with the

Are services well-led?

Requires improvement

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

GP each day to discuss clinical issues and said they could telephone the GP at anytime for advice or support. There were no concerns raised regarding the competency, knowledge or skills of the practice nurse.