Theatre Royal 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

Theatre Royal Surgery has a practice population of approximately 9300 patients.

We carried out a comprehensive inspection at Theatre Royal Surgery on 12 November 2014.

We have rated each section of our findings for each key area. 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 consistently provided good standards of care for patients.

Our key findings were as follows:

- Practice staff worked together as a team to ensure patients received the standards of care they needed.
- There were safe systems in place for ensuring patients received appropriate treatments and prescribed medicines were regularly reviewed to check they were still needed.
- Patients were protected against the unnecessary risks of infections because staff adhered to appropriate hygiene practices and regular checks were carried out.
- 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.
- Patients were treated with respect and their privacy was maintained. Patients informed us they were very satisfied with the care they received and the access to the practice. The feedback we received from patients was without exception positive.

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

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were robust safeguarding measures in place to help protect children and vulnerable adults and staff knew how to respond when concerns were identified.

Are services effective?

Good

Clinicians worked within both the National Institution for Care Excellence (NICE) guidelines and other locally agreed guidelines. People's needs were assessed and care planned and delivered in line with current legislation. Practice staff carried out clinical audits and as a result made changes where necessary to promote effective care for patients. Systems were in place for regular reviews of patients who had long term conditions and housebound patients. Multidisciplinary working was evidenced.

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 saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Feedback from patients about their care and treatment was consistently positive.

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. The practice had good facilities and was well equipped to assess and treat patients in meeting their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. High standards were

Summary of findings

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.	

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

There were a high number of older people residing in the locality. All patients aged over the age of 75 years had been informed of their named and accountable GP. GPs provided care to patients who resided in nine care homes and each home had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

Practice staff held a register of patients who had long term conditions and carried out regular reviews. For patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Structured annual reviews were undertaken to check health and care needs were being met.

Families, children and young people

Good

Appointments were available outside of school hours and the premises were suitable for children and babies. Practice staff liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. Alerts and protection plans were in place to identify and protect vulnerable children.

Working age people (including those recently retired and students)

Good

Appointments were available from 8:30am until 6:00pm every weekday. The practice was proactive in offering on-line services for making appointments and ordering repeat prescriptions. Patients over the age of 40 years were encouraged to have health checks.

People whose circumstances may make them vulnerable

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. Practice GPs provided a service for patients with learning disabilities who lived in a care home. The practice had carried out annual health

Summary of findings

checks for most patients with learning disabilities. These patients were sent a letter asking them to attend for a review. The letter had been produced in simple English and large print to assist this patient group in understanding what they needed to do. People who were not registered at the practice were seen by clinical staff as temporary patients.

People experiencing poor mental health (including people with dementia)

Care was tailored to patients' individual needs and circumstances including their physical health needs. Annual health checks were offered to patients with significant mental health illnesses. Doctors had the necessary skills to treat or refer patients with poor mental health. All staff worked within the boundaries of the Mental Capacity Act 2005 and had appropriate skills for dealing with patients with dementia.

Good

Summary of findings

What people who use the service say

We spoke with 10 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 gave us positive feedback about the standards of care they received. We were told it was easy to obtain repeat prescriptions. The appointments system had recently changed in that they could only be made on the day or the previous day. We received mixed views about this. Some patients told us they did not like the new system. Others said it was an improvement because the rate of patients who failed to attend for their appointments had fallen drastically thus freeing up available appointments.

We collected five Care Quality Commission comment cards left in the surgery prior to the inspection. All comments made were very positive. The comments included staff efficiency and how professional they were and the good standards of care provided. We did not receive any negative comments.

The Patient Participation Group (PPG) had carried out an annual survey. PPG's are an effective way for patients and surgeries to work together to improve services and promote quality care. The outcomes in the report dated 2013 to 2014 were positive. The report contained direct comments that patients had made and any recommended improvements that could be made. The patient survey report dated 2013/14 included an action plan for practice staff to work towards. For example, to reduce the number of patients who did not attend (DNA) for their appointments so that more would be available for other patients.

Theatre Royal Surgery

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 specialist advisor and a specialist advisor who had experience in practice management.

Background to Theatre Royal Surgery

Theatre Royal Surgery serves approximately 9300 patients.

At the time of our inspection there were four GP partners at the practice and two salaried GPs. Senior staff were in the process of recruiting a third salaried GP. Theatre Royal Surgery is a training practice with medical students spending time at the practice. The lead nurse is supported by two practice nurses and two health care assistants/ phlebotomists who worked varying hours. There is a practice manager and a deputy practice manager. Other non-clinical staff consisted of the reception team leader, three receptionists, two administrators and an apprentice administrator. Two medical secretaries, a finance assistant and a personal assistant to the practice manager some of which worked part time. A caretaker was also employed and three cleaning staff some of which worked part time.

The practice offers a range of clinics and services including chronic disease management, cervical smears, contraception, minor surgery, injections and vaccinations. The practice nurses specialise in some such as; diabetes, chronic obstructive airways disease, family planning and contraception. Practice staff provided advice to patients about healthy living and smoking cessation.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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)

Detailed findings

- 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 12 November 2014. During our visit we spoke with a range of staff including four GPs, the lead practice nurse, a health care assistant/phlebotomist, the practice manager, the deputy practice manager, the reception team leader, three receptionists, one administrator and the apprentice administrator. We also spoke with 10 patients who used the service and the chair of the recently disbanded 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. Relevant documentation was also checked.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients.

We reviewed safety records and incident reports and minutes of meetings where these were discussed during the last 12 months. This showed the practice had managed these consistently over time and could evidence a safe track record over the long term.

There were clear accountabilities for incident reporting, and staff we spoke with were able to clearly describe their role in the reporting process. We saw how the practice manager recorded incidents and ensured they were fully investigated. The GPs held regular meetings to review safety within the practice to ensure all relevant actions had been taken.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

The practice manager showed us the arrangements they had made for recording and ensuring incidents were investigated and any necessary actions taken. We were shown how they oversaw these to ensure they were managed and monitored. For example, the practice had not received a test result from a hospital. As a consequence practice staff made their arrangements for checking that test results had been received more robust. This information was cascaded to all clinical staff.

We reviewed a sample of 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 and timely manner.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours and those details were easily accessible.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children who had been trained to level three (higher level) to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

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.

There was a chaperone policy available to staff, posters were on display in throughout the premises and information was included in the patient leaflet. When chaperoning took place this was recorded in the patient's records. Clinical staff carried out chaperone duties and if they were not available reception staff would carry out this role. Staff had received training before they were permitted to chaperone patients. We asked two receptionists how they would carry out this duty. They demonstrated their knowledge and understanding of the role.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible by authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Staff were recording the refrigerators temperatures every day to ensure medicines remained at a safe temperature for administration.

Good

Are services safe?

Arrangements were in place to check medicines were within their expiry date and safe for use. All the medicines we checked were within their expiry dates.

Vaccines were stored in line with legal requirements and national guidance. We saw recordings that confirmed daily fridge temperatures were recorded to ensure the vaccines were stored at suitable temperatures and remained safe for administration.

There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

Cleanliness & Infection Control

All areas of the practice were visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We were shown the cleaning schedule for staff to follow and recordings that had been made where actions needed to be followed by the cleaning staff.

The practice had a lead for infection control who had received further training for this role. All staff had received training in infection control. We were told that pre-sterilised instruments were used for minor surgery.

We were shown a copy of the annual infection control audit of the premises that had been carried out by NHS Norfolk. The report was dated 20 May 2014 and informed that the practice was hygienic. We saw there were three actions that staff needed to take as a result of the audit. We discussed these with the infection control lead. They told us two of them had been completed and one was an on-going action for replacement of floor covering and sinks when clinical rooms were refurbished. We evidenced this when we visited consulting rooms.

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 (PPE) 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 in place for needle stick injury.

Legionella risk assessments had been carried out to protect patients and staff from unnecessary water borne infections.

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 the staffing requirements on its experience of how the practice operated. Consideration had been given to the access, care and treatments that patients required. We asked how staffing shortages were managed across all grades of staff. The practice manager explained that a large number of staff worked part time and were willing to work extra shifts to cover staff holidays and other absences. There were occasions when locum GPs had been used to cover GP absences.

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.

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 the standards it followed when recruiting clinical and non-clinical staff.

Monitoring Safety & Responding to Risk

There was a fire safety risk assessment in place. Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency.

The emergency lighting had been tested monthly and actions taken where defects found. Risk assessments of work stations had been carried out. We saw that fire escape routes were kept clear to ensure safe exit for patients in the event of an emergency.

There was a health and safety policy in place and staff knew where to access it.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator and all staff knew where to access it.

Emergency equipment was also checked to ensure it was in working order. We were informed by various clinical staff that GP's did not carry any medicines in their visit bags. There was a dedicated emergency medicines bag stored at the practice that GPs could take out with them.

We saw a copy of the business continuity plan. It included the contact details of services that could provide emergency assistance. Senior practice staff kept a copy of the document off site to ensure there was access to it in any eventuality.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used the National Institute for Care Excellence (NICE) guidance to ensure the care they provided was based upon latest evidence and was of the best possible quality. We saw that any revised NICE guidelines were identified and shared with all clinicians appropriately.

The clinicians we spoke with confidently described the processes to ensure that informed consent was obtained from patients whenever necessary. They were also aware of the requirements of the Mental Capacity Act (MCA) 2005 used for adults who lacked ability to make informed decisions.

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.

The GPs told us they led in specialist clinical areas such as prescribing and safeguarding. The practice nurses specialised in long term conditions such as; diabetes, family planning, contraception and chronic obstructive pulmonary disease (COPD). This work allowed the practice staff to focus on specific conditions.

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. QOF is a national performance measurement tool. 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 was about the success rate for obtaining cervical smears. The success rates were above the national average. We were informed that this would be audited again at a later date to monitor progress.

The practice had carried out a further audit because it had been reported there was a high incidence of gastro-enterology referrals within the locality. The result showed that Theatre Royal Surgery did not make excessive referrals. However, the audit identified some areas for improvement. For example, the need to document any lifestyle advice given to patients. The action points were discussed during a clinical meeting. The GP had recorded that they would carry out a further audit in three months' time based on the action points.

GPs held regular clinical meetings. The minutes informed us patient care, significant events, complaints, and patient care had been discussed. The recordings included learning from errors.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending the training courses such as annual basic life support. 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 had annual appraisals which identified learning needs from which action plans were documented. We saw that nurse's and health care assistant's appraisals were carried out by clinical staff so that their practices could be discussed and appropriately checked. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, specialist diabetes training for one of the nurse practitioners. We were shown written details about the half day training sessions held every two months that were attended by the entire practice team.

Working with colleagues and other services

A multidisciplinary team meeting was held every two months to discuss patients who were receiving end of life care. It was evident there were strong relationships in place with external professionals. A multidisciplinary meeting was held every month to discuss patients receiving end of life care and those considered to be at risk. Community staff attendance included Macmillan nurses, the

Good

Are services effective?

(for example, treatment is effective)

community matron and district nurses. We were informed that due to staffing shortages health visitors no longer attended these meetings. Practice staff were reliant upon communicating with them outside of the meetings.

There was engagement with other health and social care providers to co-ordinate care and meet patient's needs.

The practice worked with other service providers to meet people's needs and manage complex cases. Test results, Xray results, letters from the local hospital including discharge summaries, out of hour's providers and the emergency service were received at the practice each morning. This information was disseminated to the respective GPs for them to review and if necessary invite the patient to make an appointment for a follow-up or a referral to hospital or a physiotherapist.

Patients would be contacted about their test results and informed by the GP either face to face or by telephone consultation. A medical secretary may also pass on information as instructed by the GP about test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

There were named GP's for each of the nine care homes and they visited their respective home on a weekly basis. They also attended if requested to do so by the care home staff.

Information Sharing

Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Patients and staff reported that this system was easy to use.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. The senior partner told us they did not share patient records with other services but provided the relevant information they needed to make a full assessment of the patient.

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 patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system included a facility to flag up patients who required closer monitoring such as children at risk.

The practice manager designed and maintained the practice web site and produced regular newsletters to inform patients of any developments within the practice and locally. For example, staff changes, staff training, text messaging appointment reminders, voluntary services and the proposed flu vaccination clinics.

Consent to care and treatment

We spoke with 10 patients and they all confirmed they felt in control of their 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. However, a GP who carried out joint injections had not obtained written consent beforehand. This did not comply with the GMC guidelines for consent. We raised this matter with the practice manager who assured us it would be addressed promptly.

GPs were aware of the requirements within the Mental Capacity Act (MCA) 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

Good

Are services effective?

(for example, treatment is effective)

they were taking. 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 leaflets in the waiting area for patients to take away with them. Posters were displayed in all three waiting areas advising patients where they could find local health information. There was also health and welfare information and links to those providers on the practice web site.

Patients with learning disabilities or mental health conditions were offered an annual health review. Free health checks were available to patients between the ages of 40 and 74. Patients aged 75 and over and those identified to be at risk were also offered annual health checks.

Letters were sent to patients who had learning difficulties when their cervical smear was due included an information leaflet. It provided an explanation of why the test was necessary, a description of the procedure and how the patient was informed of the result. Each paragraph included pictorial explanations to assist the patients in understanding why they needed the test.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed that reception staff greeted patients in a polite and courteous manner. When patients made appointments by telephone we overheard receptionists giving patients choices and respected when patients were available to attend on some days.

A receptionist told us they could ask a patient to speak with them privately in an unoccupied room to protect their confidentiality.

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. They told us this service was offered to them by clinical staff. Some patients 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.

Five patients completed CQC comment cards to provide us with feedback on the practice. Patients said they felt the practice offered a good service and were professional and helpful. All of the 10 patients we spoke with made positive comments about their care they received.

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 patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, respondents said the GP involved them in care decisions and they felt the GP was good at explaining treatment and results.

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 and had received training.

The lead nurse 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

Practice staff maintained a register of carers to enable clinical staff to provide support and guidance for them. Information for carers was also posted on the practice website. The patient participation Group (PPG) held a 'free patient information event' on 30 April 2014 at a local venue. It included attendance of representatives for a range of organisations who provided support. For example, Autism Anglia, Marie Curie, Diabetes UK and others.

The practice manager informed us the respective GP contacted bereaved families and went out to visit them. They also offered the opportunity for them to speak with the GP or a nurse whenever they wanted to.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

Practice staff recognised the long term condition needs of its practice population. For example, diabetes and chronic obstructive pulmonary disease (COPD). The nursing staff took a particular interest in these groups of patients and had received specialist training in this aspect of care.

We saw the Patient Participation Group (PPG) report for 2013 to 2014. PPG's act as representative for patients and work with practice staff in an effective way to improve services and promote quality care. The report informed us that patients were satisfied with the service they had received. From this the PPG had met with senior practice staff and discussions held about the results of the survey and where improvements could be made. The main point that needed addressing was that some patients had commented about the length of time they waited to be seen after their arrival at the practice. The practice manager had reported that the practice was doing better than other local practices for waiting times but they would monitor the situation.

The other area of improvement needed was to reduce the number of patients who did not attend (DNA) for their appointments which reduced available access for other patients. A receptionist had suggested that pre-bookable appointments could continue to be made by clinical staff in order to monitor/review patients but this facility should otherwise be closed. This meant that patients were only able to make appointments up to one day on advance or on the day. It was agreed to pilot this scheme for a period of six months and patients were informed before the system had commenced. The practice manager told us the arrangements had resulted in a drastic reduction in the number of DNA's. This was confirmed by two of the patients we spoke with.

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. We asked administration staff how long it took to send out the referral letters. We were told they were completed within two days and urgent ones on the day they were requested.

Efforts had been made to prevent disruption to patient care whilst arrangements were being made to recruit another GP. Senior staff listened to patient's opinions and had responded to them by producing a newsletter that included explanations to patients and to raise their awareness of how the practice operated.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We were told that people visiting the area would be seen as temporary patients. A GP informed us they had some travellers on their patient list who were registered as permanent patients.

A number of staff employed at the practice spoke various languages. Staff told us that translation services were available for patients who did not have English as a first language. Practice staff told us that there had been a high number of Portuguese patients registered at the practice. There was also written information for patients whose first language was Portuguese.

The premises were accessible by patients who had restricted mobility. There were two toilets for disabled people. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

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 about how they were treated by staff.

Access to the service

Appointments were available each weekday mornings and afternoons. Patients could make appointments from 8:30am and up to 6:00pm to enable those such as working patients and children to attend before and after school hours. We asked patients if they were satisfied with the opening times. They told us they were satisfied.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice website and in the patient leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

Patients confirmed that they could see a doctor on the same day if they needed to. The appointments system had recently been changed to on the day or following day appointments only. We received mixed views about the new appointments system. Some patients told us they did not like it, others felt it was an improvement because the rate of patients who failed to attend for their appointments had fallen drastically thus freeing up available appointments for others to take.

Patients who requested a home visit were contacted by telephone by a GP to check the visit was essential. However, if the GP had prior knowledge of the patient they may visit them at home without a telephone consultation. Home visits were made on the same day they had been requested. Regular home visits were made by GP's to patients who were housebound.

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.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The patient leaflet included information about how to make a complaint if patients needed to.

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. We saw evidence that complaints were discussed during clinical and business meetings, depending upon the nature of the complaint.

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 clear vision to deliver high quality care and promote good outcomes for patients by staff who were appropriately trained.

We spoke with 13 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of a variety of meetings held by practice staff and saw that that the vision and values were still current.

Governance Arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a national performance measurement tool. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at meetings and action plans were produced to maintain or improve outcomes. There was an administrator whose dedicated role was collation of the QOF results.

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. We found that senior staff regularly attended the CCG meetings to gain further insight for potential performance improvements. There were specific identified lead roles for areas such as prescribing, safeguarding and diabetes. Responsibilities were shared among GPs, nurses and the practice manager.

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

Leadership, openness and transparency

The practice manager had cascaded information to other staff in ensuring the day to day operations were carried out effectively. Staff we spoke with were clear about their 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. For, example a receptionist had suggested the recent change in the appointments system whilst senior staff recruited a salaried GP. This served to maximise appointments available to patients to ensure they were seen when needed.

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

Until recently the practice had an active Patient Participation Group (PPG). The PPG had carried out annual surveys and met every month. PPGs act as a representative for patients and work with practice staff in an effective way to improve services and to promote quality care. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The report dated 2013 to 2014 included an action log of suggested improvements. Where possible these had been acted on.

Due to unavoidable circumstances the PPG had disbanded at the end of June 2014. At the time of the inspection efforts were being made to establish a Patient Virtual Group (PVG) who would communicate with senior practice staff electronically.

The practice had gathered feedback from staff through meetings and regular training events. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy and staff were aware of their rights in using it.

Management lead through learning & improvement

All GPs and staff attended a half day training event every two months. We looked at the topics discussed during these events. The training included patient care, review of significant events and the day to day operations within the practice.

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files including the

Are services well-led?

Good

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latest recruit and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and any requests they made.

The practice manager told us they regularly checked the appointments system to ensure there were enough to meet patient demands. Patients we spoke with and the comment cards we received informed us they could get appointments when they needed them.

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, practice staff received two test results but one was for a patient who was not registered at the practice. Staff took immediate action to locate the surgery the patient was registered at to enable them to prescribe safe amounts of a medicine.