

Theatre Royal Surgery

Quality Report

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Date of inspection visit: 28 November 2017
Date of publication: 27/12/2017

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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Requires Improvement

overall. (Previous inspection 12 November 2014- rated good overall and good for all domains.)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires improvement

People with long-term conditions – Requires improvement

Families, children and young people – Requires improvement

Working age people (including those recently retired and students) – Requires improvement

People whose circumstances may make them vulnerable – Requires improvement

People experiencing poor mental health (including people with dementia) - Requires improvement

We carried out an announced comprehensive inspection at Theatre Royal Surgery on 28 November 2017. We carried out this inspection as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage safety incidents. When incidents did happen, the practice learned from them and improved their processes.
- The practice had systems and processes in place to ensure patients were safeguarded from harm.
- The practice did not have effective risk assessments in place relating to fire or legionella. Immediately following the inspection, the practice sourced a company to complete a fire risk assessment and a legionella risk assessment as these were last completed in 2010 and 2012.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice had achieved 99.8% for the Quality and Outcomes Framework.

Summary of findings

- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system was not always easy to use; however the management team were aware of this and had implemented a new phone system and upskilled staff to address this issue. Results relating to access from the GP Patient survey were lower than local and national averages.
- Management were visible, approachable and staff felt proud to work in the practice.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

- The practice had set up a walking group for patients with diabetes to improve health outcomes such as lowering blood pressure and increasing physical activity. Due to the popularity, this group had expanded to all patient groups. The practice had found and provided evidence to show decreased social isolation including those recently bereaved and they had ensured the group was accessible for

those with a disability, including visual impairment. The group walked every day and the practice staff assisted those with lower mobility, or disabilities so that they could still attend. The practice could demonstrate that patients health had improved since joining the group; for example, some patients no longer needed medicines to control their blood pressure.

The areas where the provider **must** make improvements are:

- Ensure that the practice assesses and mitigated the risks to the health and safety of service users and staff.

The areas where the provider **should** make improvements are:

- Continue to assess and ensure improvement to patient satisfaction relating to access to appointments as seen in the national GP patient survey results.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General 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	Requires improvement 
People with long term conditions	Requires improvement 
Families, children and young people	Requires improvement 
Working age people (including those recently retired and students)	Requires improvement 
People whose circumstances may make them vulnerable	Requires improvement 
People experiencing poor mental health (including people with dementia)	Requires improvement 

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 adviser and a practice manager specialist advisor.

Background to Theatre Royal Surgery

Theatre Royal Surgery provides services to approximately 9,000 registered patients in a semi-rural area in Dereham, Norfolk. The practice is run by three male GP partners who are supported by one salaried GP (female) and a trainee GP (female). The practice employs one advance nurse practitioner who works closely with the GPs, three practice nurses, and emergency care practitioner, two healthcare assistants who can also do phlebotomy and one phlebotomist. Other support staff include an operations manager, a finance manager, a management assistant, three administrators six receptionists and two secretaries. The practice holds a general medical services contract with NHS England.

The practice is a training practice and supports medical students training to become GPs. At the time of our inspection, there was a foundation year doctor at the practice.

The practice is open between 8am and 6.30pm Monday to Friday. Patients are required to book these appointments in advance. Urgent appointments are available for people that need them, as well as telephone appointments. Online appointments are available for patients to book in advance.

When the practice is closed patients are automatically diverted to the GP out of hour's service provided by IC24. Patients can also access advice via the NHS 111 service.

We reviewed the most recent data available to us from Public Health England which showed the practice has a smaller number of patients aged 25 to 39 years old compared with the national average. It has a larger number of patients aged 65 to 85 compared to the national average. Income deprivation affecting children is 17%, which is higher than the CCG average of 13% and lower than the national average of 20%. Income deprivation affecting older people is 14%, which is higher than the CCG average of 12% and lower than the national average of 16%. Life expectancy for patients at the practice is 80 years for males and 83 years for females; this is comparable to the CCG and England expectancy which is 79 years and 83 years.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had a suite of safety policies which were regularly reviewed and communicated to staff. Staff were required to sign these policies once they had read them. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. Staff spoken to were clear about their responsibilities in relation to safeguarding.
- All staff received up-to-date safeguarding and safety training appropriate to their role. GPs and nurses were trained to safeguarding level three. Staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. The practice had good communication with the midwives and health visitors.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was an effective system to manage infection prevention and control (IPC). There was a completed audit with associated action plan. The IPC lead was the lead nurse. There were cleaning schedules in place and

hand hygiene audits were completed every six months. The IPC lead had completed further training for the role and fed back updates to the team. There were systems for safely managing healthcare waste.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. Calibration and electrical testing was completed annually.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role. There was a locum induction pack and locum staff files that we checked contained relevant employment checks.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Clinicians could give a detailed explanation of how they would manage a patient with suspected sepsis and had up to date knowledge of guidance. There was also a template on the clinical computer system that could be followed.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the practice held regular meetings with other agencies and had the same computer system so notes could be shared with patient consent.

Are services safe?

- Referral letters we reviewed included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had a detailed check list for the emergency equipment, which was checked monthly. The practice kept prescription stationery securely and monitored its use in line with guidance.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines. This included the review and safe monitoring of patients on high risk medicines, including methotrexate and lithium. Records we viewed for these patients showed safe management and routine blood testing.

Track record on safety

The practice did not have effective systems in place to maintain a complete safety record.

- There were risk assessments in relation to safety issues, however these required review. For example, the fire risk assessment had last been completed in 2010, which was prior to the extension that was built in 2011. The practice did carry out regular fire alarm testing and had equipment including fire extinguishers and emergency lighting checked regularly. Since the inspection, the practice have provided a risk assessment carried out 30 November 2017, and have an assessment booked by an external company for January 2018. A legionella risk

assessment had last been completed in 2012 and the practice were not monitoring water temperatures. After the inspection, the practice informed us they had booked a legionella assessment for 12th December 2017 and were going to implement a system for monitoring water temperatures.

- There was an up to date health and safety risk assessment which covered areas including home visits, work station assessments and building and premises.
- The practice monitored and reviewed most activity. This helped it to understand risks and gave a clear, accurate and current picture that led to some safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Staff were able to give examples of significant events they had raised and the outcomes of these events.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, a patient was unaware that antibiotics needed to be collected after a urine sample. Therefore, the practice had updated the form handed to patients to explain the process of prescribing and collecting antibiotics.
- There was a system for receiving and acting on safety alerts. These alerts came to the operations manager; the lead GP for prescribing then ran any relevant searches and acted on the results as appropriate. All alerts were kept in a folder for referencing when necessary. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. These were readily available for clinicians and discussed in clinical meetings.

- Records we viewed showed patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice were in line with local and national averages for the prescribing of daily quantity of hypnotics.
- The practice were in line with local and national averages for the prescribing of antibacterial prescription items.
- The practice were in line with local and national averages for the prescribing of antibiotic items prescribed that are cephalosporins or quinolones.
- We saw no evidence of discrimination when making care and treatment decisions in the records we viewed.
- Staff advised patients what to do if their condition got worse and where to seek further help and support. There were protocols available for reception staff to follow when triaging patients and there was a duty doctor available for advice.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice worked closely with the district nursing team to ensure holistic management of these patients.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, the nursing team had specific qualifications in diabetes and respiratory conditions.
- The practice had achieved 100% for nationally reported data relating to long-term conditions including diabetes, asthma, COPD, hypertension and atrial fibrillation data.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above line with the target percentage of 90% at 96-100%.
- The practice had arrangements to identify and review the treatment of newly pregnant women.
- Children who were unwell were offered appointments on the same day.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 81%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Are services effective?

(for example, treatment is effective)

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 61 patients with a learning disability and had reviewed 38 of them in 2017/18 at the time of our inspection.

People experiencing poor mental health (including people with dementia):

- 90% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was 4% above the CCG average and 7% above the national average.
- 97% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was 4% above the CCG average and 7% above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 94% of patients experiencing poor mental health had received discussion and advice about alcohol consumption; this was above the CCG average of 92% and the national average of 91%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The most recent published Quality Outcome Framework (QOF) results were 99.8% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 96%. The overall exception reporting rate was 10% compared with the CCG and national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- Performance for diabetes related indicators was 100%; this was 10% above the CCG average and 9% above the national average. The exception reporting rate for each of the sub indicators was generally in line with local and national averages. The prevalence of diabetes was 8% which was 1% above the CCG and national average.
- Performance for mental health related indicators was 100%. This was 7% above the CCG average and 6% above the national average. The exception reporting rate for the sub indicators was generally below or in line with local and national averages. The prevalence of patients with recorded mental health conditions in the practice was 1%, which was equal to the CCG and national averages.
- Performance for dementia related indicators was 100%, which 4% higher than the CCG average and 3% above the national average. The exception reporting rate for the sub indicators was below local and national averages. The prevalence of dementia was 1% which was equal to the CCG and national averages.
- The performance for depression was 100%. This was 4% above the CCG average and 7% above the national average. The prevalence of patients recorded as having depression was 7%, which was lower than the CCG prevalence of 8% and the national prevalence of 9%. The exception reporting rate for the sub indicator was below local and national averages.

The practice was actively involved in quality improvement activity and regularly completed both clinical and non-clinical audits; 20 audits had been completed in the past year and changes were implemented as a result.

- For example, the practice had run an audit to ensure effective monitoring of the renal function of patients on a specific medicine. From this, the practice had added a prompt to the patient record, implemented a monitoring protocol and placed a reminder on the system of when to stop the medicine. On re-audit, the practice found a 17% improvement of the patients being appropriately monitored.

Effective staffing

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, staff had been involved in the recent re-structure of the practice and some had been promoted in to management positions.
- The practice provided staff with ongoing support. This included a tailored induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation and students. The induction process for healthcare assistants included the requirements of the Care Certificate. Staff reported there was an 'open door' policy and that support was available on site at all times.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice helped to support a care home liaison nurse. The nurse attended care homes supported by the practice to carry out visits. The lead GP for the care homes would also attend every two weeks to review patients and complex cases. Feedback received from two of the care homes was extremely positive about the way the GPs and nurse cared for the patients and the communication with the practice. The practice had run an audit which showed that most admissions were over the weekend, where they did not have access to the GP surgery. The surgery were keen to holistically treat patients to ensure unplanned admissions were minimised.

- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- The practice could demonstrate that they held multidisciplinary case review meetings where all patients on the palliative care register were discussed.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. Patients we spoke with reported the clinical staff explained treatments to them and took in to account their views and made decisions together.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Are services effective?

(for example, treatment is effective)

- The practice monitored the process for seeking consent appropriately.
- The practice gained written consent for minor surgeries and recorded this on the patients notes.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Staff could give examples of when they had done this.
- All of the 12 patient Care Quality Commission comment cards we received were positive about the service experienced. Comments related to the caring nature of the staff and that they would recommend the practice. Patients spoken with on the day aligned with this view and reported that the GPs were well respected within the community.

Results from the July 2017 annual national GP patient survey showed patients responded in a mixed manner when answering questions relating to being treated with compassion, dignity and respect. 221 surveys were sent out and 126 were returned. This represented 57% completion rate. For example:

- 82% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 81% of patients who responded said the GP gave them enough time; compared to the CCG average of 87% and the national average of 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; compared to the CCG average of 95% and the national average of 95%.

- 79% of patients who responded said the last GP they spoke to was good at treating them with care and concern; compared to the CCG average of 85% and the national average of 86%.
- 95% of patients who responded said the nurse was good at listening to them; compared to the CCG average of 92% and the national average of 91%.
- 94% of patients who responded said the nurse gave them enough time; compared to the CCG average of 93% and the national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; compared to the CCG average of 98% and the national average of 97%.
- 93% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; compared to the CCG average of 91% and the national average of 91%.
- 78% of patients who responded said they found the receptionists at the practice helpful; compared to the CCG average of 87% and the national average of 87%.

We spoke with the practice about the results of this survey. The practice had recently undergone a re-structure and was in the process of appointing a new GP partner. The practice felt that once the re-structure had taken effect, results from this survey would improve. Patients spoken with on the day of the inspection had differing views from those in the survey, as did the CQC comment cards. Patients reported that the GPs were caring, responsive to their needs and always took the time to listen to all issues the patients had. All patients we spoke with were happy with the services the clinicians provided.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than

Are services caring?

English, informing patients this service was available. The practice had a very small number of patients that required this service. Reception staff were aware of how to use this service for these patients.

- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. The practice had leaflets available in larger fonts for those that found these useful.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment and advice was available on website.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 155 patients as carers (1.7% of the practice list).

- There was a poster available in reception to direct carers to local support groups and information available on the website.
- Staff told us that if families had experienced bereavement, their usual GP contacted them by phone call and offered an appointment to suit the patients needs. Where appropriate, the GP would also provide a home visit to offer support. The practice also held a walking group and, where appropriate, would offer bereaved patients the option to come along. The practice could evidence that patients who had been bereaved had gone to the walking group and now regularly attended.

Results from the national GP patient survey showed patients responded in a mixed manner to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 79% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 71% of patients who responded said the last GP they saw was good at involving them in decisions about their care; compared to the CCG average of 83% and the national average of 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments; compared to the CCG average of 90% and the national average of 90%.
- 86% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; compared to the CCG average of 86% and the national average of 85%.

These results differed from patients reports on the day of inspection and from the CQC comment cards. Patients reported that GPs involved them in their treatment choices and care decisions and always took the time to explain these to the patients. The practice were aware of the lower areas of performance and had an action plan in place to implement change and improve patient satisfaction.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice had a high number of patients in care homes and was actively working with the nurse liaison to reduce unplanned admissions.
- The practice improved services where possible in response to unmet needs through audit and implementation of new strategies. For example, the practice employed an emergency care practitioner to meet patient demand and offer a wider scope of appointments.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services, including the district nurses.
- The practice had set up a walking group for patients with diabetes to improve health outcomes such as lowering blood pressure and increasing physical activity. However, this group had expanded to all patient groups due to popularity. The practice could evidence decreased social isolation and had ensured the group was accessible for those with a disability, including visual impairment. The group had also been used to improve socialisation among those recently bereaved. The group walked every day and the practice staff assisted those with lower mobility, or disabilities so that they could still attend. The practice could demonstrate that some patients health had improved since joining the group; for example, some patients no longer needed medicines to control their blood pressure.

Older people:

- All patients had a named GP who supported them in their home, whether it was at home, in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice had a higher than average number of care homes. The practice had recognised the needs of this patient group and the GP supported the locality nurse who provided home visits for those in local care homes. Feedback from these care homes was wholly positive about the service the practice provided. This was part of a pilot with the clinical commissioning group.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had an active social media platform to inform patients and to share feedback from the local population.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had a staff member who had undertaken domestic abuse training and had cascaded this learning down to the team.
- The practice flagged vulnerable patients notes to ensure they received care tailored to them. For example, those patients with visual impairment had a flag on their system so the clinician and reception staff knew to assist them to the waiting and clinical rooms.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was situated in a dementia friendly town. The practice had booked all staff on to additional training to further enhance the support offered to those patients living with dementia.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mixed in comparison to local and national averages. 221 surveys were sent out and 126 were returned. This represented 57% completion rate. For example:

- 68% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 51% of patients who responded said they could get through easily to the practice by phone; compared to the CCG average of 70% and the national average of 71%.
- 77% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; compared to the CCG average of 86% and the national average of 84%.
- 76% of patients who responded said their last appointment was convenient; compared to the CCG average of 84% and the national average of 81%.
- 49% of patients who responded described their experience of making an appointment as good; compared to the CCG average of 73% and the national average of 73%.
- 64% of patients who responded said they don't normally have to wait too long to be seen; compared to the CCG average of 57% and the national average of 58%.

The practice were aware of the lower than average areas of the survey, particularly relating to the phone access and making an appointment. As a result, the practice had installed new phone lines which gave a more effective queuing system for patients. The practice had also undergone a re-structure of staffing and had upskilled more members of staff to be reception trained in order to address the issue. The practice had closely analysed the skill mix within the clinical staff and had appointments available for GPs, nurses and an emergency care practitioner. The practice was active in educating patients about which clinician was best suited to assess and treat certain conditions. There was a leaflet with an easy to read chart available in reception and on the website.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Are services responsive to people's needs?

(for example, to feedback?)

- Information about how to make a complaint or raise concerns was available and it was easy to do. There were complaints leaflets available in reception. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Eight complaints were received in the last six months. We reviewed four complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. For example, there was now a sign in reception that directed patients to reception if they required a glass of water after a complaint was made relating to a lack of water dispensers.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff spoken to reflected this and felt supported by the management team. Staff reported they were proud to work in the practice.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities, including plans to address the shortfall of GPs in the area. The practice were active in the overseas GP recruitment campaign and had addressed skill mix within the practice to meet patient demand by recruiting nurse practitioners and an emergency care practitioner. The practice had also worked closely with the CCG in order to develop strategies to improve employment. The practice had applied for a list closure in order to continue to provide patients with the level of care they were achieving. However, this had been unsuccessful.
- The practice had successfully employed a new salaried GP to start in December 2017.
- The practice developed its vision, values and strategy jointly with staff.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy to ensure it was achievable and address and shortfalls that may arise.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice and many had worked there for a number of years. Staff turnover was low and satisfaction was high, particularly with a recent restructure. For example, staff were positive about how the management team had involved them in the decision to not recruit a new practice manager, favouring to promote staff internally. Staff reported management were approachable and attended social events.
- The practice focused on the needs of patients and adapted services to meet their demands.
- Leaders and managers had a system to act on behaviour and performance inconsistent with the vision and values, should it arise.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed and we saw evidence of shared learning from concerns in meeting minutes.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the previous year. When staff had changed roles, appraisals were booked for one year after their start date. Staff were supported to meet

Are services well-led?

Good 

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

the requirements of professional revalidation where necessary. Staff reported training was encouraged and that the practice would support them through training where viable.

- Clinical staff, including nurses and the emergency care practitioner, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. There were clear systems in place for a zero tolerance approach to staff safety, and staff felt protected by this.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff reported they felt they were treated equally.
- There were positive relationships between staff and teams. This was evidenced through regular social events and work based morale initiatives.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. They knew who to report to and felt confident and supported in doing so.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were processes for managing most risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety; however, the practice did not have a recent fire or legionella risk assessment. The practice was responsive to these findings and sourced companies to complete these after the inspection.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints and these were well managed within the practice.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality in areas including prescribing and infection control.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. The management team had a good overview of the performance of the practice.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, there was an action plan in place to address the GP Patient Survey results.

Are services well-led?

Good 

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

- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required. We saw evidence of this, and the practice internally reported them as significant events.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, all staff were involved in the recent restructure of the practice to help shape the development of the practice. Management listened to staff and had promoted internally where possible to further enhance staff skill. Staff reported they felt involved in the practice and that the management would try to implement change suggested where appropriate.
- There was an active patient participation group (PPG). We spoke with one member of the PPG who reported a positive working relationship with the practice. The PPG

were previously active with assisting with flu days. The practice also liaised with local groups and advertised them in the practice. For example, the practice had leaflets available for local mental health support groups.

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example, after a recent restructure, the management team had decided where possible to promote internally. The practice were a teaching practice and keen to develop training GPs, as well as apprentices.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements with all members of the team.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. Staff reported training was encouraged and that the practice supported them through the process. For example, a nurse was undertaking a prescribing qualification that was funded by the practice and support was being offered throughout the training. Management reported this support would continue once the qualification had been gained.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:</p> <ul style="list-style-type: none">• The last fire risk assessment had been completed in 2010 and had not been updated.• The last legionella risk assessment had been completed in 2012 and the practice were not monitoring water temperatures as required.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	