Caskgate Street Surgery

Quality Report

3 Caskgate Street,
Gainsborough,
Lincolnshire
DN21 2DJ
Tel: 01427 619033
Website: www.caskgatestreetsurgery.co.uk

Date of inspection visit: 7 May 2014
Date of publication: 07/10/2014

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

Summary of findings

Contents

Summary of findings

Overall summary

Caskgate Street Surgery provides a range of primary care medical services to approximately 10,200 people.

During our visit to the practice on 07 May 2014 we spoke with patients who used the service and met with members of the Patient Participation Group. We spoke with doctors and other members of staff. We looked at procedures and systems used and considered whether the practice was safe, effective, caring, responsive to people's needs and well-led.

Caskgate Street Surgery was safe. There were appropriate safeguarding procedures in place, although the vulnerable adults safeguarding policy did not refer to the reporting guidelines the practice was following. Medicines were managed safely, the practice was clean and hygienic and there were arrangements in place to respond to emergencies. The emergency resuscitation equipment was not packed in readiness so that it could be easily transported by one person. Some areas of the building were worn and in need of redecoration.

The practice was effective and had procedures in place that ensured care and treatment was delivered in line with appropriate standards. There was an effective system in place to manage the health reviews of patients with long term conditions and there were effective working links with other health and social care providers.

The practice was caring, where patients were treated attentively and with dignity and respect. Patients spoke very positively of their experiences and of the care and of the attention offered by staff. The GPs provided personal intervention in people's end of life care.

The practice was responsive to people's needs and had a good understanding of the demographic of its population and adjusted its resources to ensure patient's needs were met.

The practice was well led. There was an active patient representation group in place. There was a philosophy of attentive care and kindness that was shared by all staff. There were effective governance procedures in place and a system of using information from patients and from records to monitor the effectiveness of the 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?

The practice was safe. Patients were provided with person-centred care from staff who were suitably trained and competent. Patients were protected from harm, although safeguarding policies for vulnerable adults did not refer to the reporting procedures and the guidelines that the surgery was following.

The emergency resuscitation equipment was not packed so that it could be immediately carried to the scene of an emergency by only one member of staff.

The practice was a suitably safe environment for patients. Some areas of the building were worn and in need of redecoration.

Are services effective?

The practice was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs had been consistently met in a timely manner.

We saw a completed clinical audit cycle. The audit cycle we looked at assessed the improvements made in the way that patients were screened for cervical cancer.

There was an effective system in place to manage the health reviews of patients with long term conditions and there were effective working links with other health and social care providers. This was particularly the case in relation to people who were receiving care at the end of their lives.

We found that staff had access to the training they needed to carry out their roles effectively and were supported through annual appraisals.

Are services caring?

The practice was caring. We found that people were treated with dignity, respect and compassion. Patients spoke very positively of their experiences and of the care and attention offered by the staff. The sensitive and respectful attitudes and behaviour of the staff that we observed were reflected in patients' experiences.

Consent was obtained and care and treatment discussed with patients in order for them to make an informed decision.

Patients were involved in planning their care and treatment and patients receiving end of life care were provided with personal care by the GPs at the practice.

Summary of findings

Are services responsive to people's needs?

The practice was responsive to people's needs. There was a culture within the organisation that promoted listening to patients' views and opinions when they were seen by GPs or by nurses. We found that the practice had a good understanding of the demographic of its population and adjusted its resources to ensure patients' needs were met.

The complaints policy had ensured that people's issues had been listened to and responded to within appropriate timescales and that patients' suggestions had been acted upon.

The practice had initiated discussions with NHS England and with their Local Authority about ways to improve their services for their existing patients and for an anticipated increase in numbers of patients.

Are services well-led?

The practice was well led. The partner leadership team had a vision and a purpose for improving their service. Staff were supported in regard to their welfare and were supported and encouraged by GPs through formal clinical meetings and through less formal daily support when this was required.

The culture of the practice was open and staff told us they felt empowered to report any concerns or to make suggestions for improvement. Staff were encouraged to take ownership of their responsibilities.

There was a strong focus on improving quality of care through learning. This was evident across all staff groups within the practice.

The practice was supportive of patients' views. Members of the patient participation group (PPG) told us that they felt supported and listened to.

Summary of findings

What people who use the service say

We spoke with 13 patients during our visit to the practice. All of the patients we spoke with were very complimentary about the care and treatment they had received and said that the practice provided a helpful and satisfactory service for them. Patients told us they had been treated with respect by staff.

We saw that the results of patient surveys that had been carried out by the practice showed that patients were pleased with the service and that the practice had responded to their views and complaints. The patient survey that had been carried out by the practice showed that all patients were satisfied with the service.

The 12 comment cards that patients had completed prior to our visit to the practice, showed that patients were similarly satisfied with the service and were pleased to have a named doctor who they could see.

127 patients had completed the GPAQ (General Practice Assessment Questionnaire) survey, which is approved by the Royal College of General Practitioners for GP revalidation and incorporates the Primary Care Assessment Survey (PCAS). The survey was open to patients in January and February 2014. The results showed that patients had very positive experiences of the service, although they also indicated that waiting times to see a GP were longer than they wanted.

These findings were reflected in the national GP NHS patient survey carried out in 2013 with an overall patient rating above the national average of 84%.

Areas for improvement

Action the service COULD take to improve

Caskgate Street Surgery's safeguarding policies for vulnerable adults did not refer to the published guidelines they are following.

Some areas of the surgery were worn and in need of redecoration.

Caskgate Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and a GP specialist advisor and the team included a CQC inspector and a specialist advisor Practice Manager.

Background to Caskgate Street Surgery

Caskgate Street Surgery in West Lincolnshire Clinical Commissioning Group (CCG) area provides a primary medical service from one location to approximately 10,200 patients registered with the surgery. The surgery does not have any branch surgeries.

Why we carried out this inspection

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

How we carried out this inspection

We conduct our inspections of primary medical services, such as Caskgate Street Surgery by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

We carried out an announced visit on 07 May 2014. During our visit we spoke with the three doctors, the practice manager, the practice nurse and a receptionist. We also spoke with patients using the service and with three members of the patient participatory group (PPG) on the day of our visit. We observed interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed CQC comment cards completed by patients using the service on that day where they had shared their views and experiences.

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

? Is it safe?

? Is it effective?

? Is it caring?

? Is it responsive to people's needs?

? Is it well-led?

Are services safe?

Summary of findings

The practice was safe. Patients were provided with person-centred care from staff who were suitably trained and competent. Patients were protected from harm, although safeguarding policies for vulnerable adults did not refer to the reporting procedures and the guidelines that the surgery was following.

The emergency resuscitation equipment was not packed so that it could be immediately carried to the scene of an emergency by only one member of staff.

The practice was a suitably safe environment for patients. Some areas of the building were worn and in need of redecoration.

Our findings

Safe patient care

There were effective arrangements for reporting serious incidents in line with NPSA (National Patient Safety Agency) guidance. We found that the practice tracked their performance both overall and as a result of incident reporting and complaints. Staff had been encouraged to report these events. Where less serious concerns had arisen, they had been addressed in a timely way and we saw evidence they had been discussed at practice meetings. Where concerns were raised they were investigated and changes made, where possible, as a result.

Staff we spoke with were aware of their roles and responsibilities in reporting incidents relating to patient safety. This meant that events that may affect patient care were identified and investigated in a timely manner.

Learning from incidents

Staff informed us that there were set times within the practice meetings where patients at risk were discussed and their cases were used as learning sets. We saw that staff learned about treatment and care pathways in the learning sets that were also a feature of the regular palliative care meetings and the clinical governance meetings. One nurse we spoke with explained how the practice has dedicated monthly learning sessions for nurses that are led by a GP and that this had allowed nurses to learn from GPs. We were told that the last learning session was an 'unusual heart sounds' session.

We found that action and learning plans had been shared with all relevant staff when serious events had been reported and after any investigation had been completed through a significant event analyses.

The practice used a 'serious incident update' form to notify the local Clinical Commissioning Group (CCG) of individual events. We saw a completed form for one event. We found that the significant events analysis (SEA) included a discussion and dissemination among staff in order for lessons to be learned and improvements to be made. One nurse told us that the practice's monthly learning sessions had enabled nurses to learn from these reported incidents.

Are services safe?

The CCG had monitored the practice's performance on a monthly basis in relation to the standard and timeliness of significant adverse event reporting. We contacted the CCG who confirmed that they had regular meetings with the surgery to me

Safeguarding

Safeguarding filters and alerts had been built into the computer software system used by the practice so that GPs were able to immediately identify any concerns relating to children and to vulnerable adults. There was a record of children on a Local Authority Child Protection Plan (CPP) which they were able to use to ensure children at risk were clearly identified by the surgery. We saw evidence that safeguarding records for children were extensive and detailed where they had been completed by GPs. The GPs were able to use this record to track the pathway care of a child and any safeguarding matters that they should be aware of.

The safeguarding policies showed the surgery had a nominated lead and staff were expected to report to them any concerns if children, or vulnerable adults were considered to be at risk of harm. There were suitable reporting procedures in the policy that directed staff to the child protection co-ordinator at Lincolnshire Community Health Services and to other NHS clinical professionals.

The vulnerable adults policy did not refer to the reporting procedure that the practice would use, or to the Local Authority guidelines that should be followed. However, three non- clinical and two clinical staff confirmed they would report any concern to the practice's safeguarding lead.

Monitoring safety and responding to risk

There were effective arrangements in place for reporting serious incidents in line with NPSA (National Patient Safety Agency) guidance and for these incidents to be monitored by the local Clinical Commissioning Group.

Patient care had been planned for emergency care and treatment. We found that whilst patients were in the building there was always a GP available for emergency situations. All staff had been trained in cardio-pulmonary resuscitation (CPR) and to use a defibrillator. The practice had an automated external defibrillator, a portable electric device to apply electrical therapy to re-establish an effective heart rhythm. All the emergency medicines were within their use-by date and all the equipment had been regularly checked and maintained.

The emergency resuscitation equipment that was stored in the lower floor level of the practice had been checked daily to ensure it was within a safe use-by date and was clean. However, the equipment was not packed in readiness to be transported by one person. We saw that the medicines and the equipment were stored in two three-drawer cabinets and the automated external defibrillator (AED) and an oxygen cylinder were stored nearby. A nurse explained that two people would be required to carry all of the equipment. This matter was discussed with the practice when we provided feedback at the end of the inspection visit. They advised us they would review this procedure and would ensure that a single carry pack would be used to transport all the emergency equipment.

Reception staff were trained in call handling and in the event that a patient had chest pain or was excessively out of breath, they knew what action to take. We found that the computer and phone system incorporated an alarm which alerted all staff in the event of an emergency. There were also alarm buttons in each GPs and nurse surgery should an emergency arise during a patient consultation.

We saw evidence of staffing levels being monitored on a daily basis through the use of planning and timing of appointments. We saw that appropriate staffing levels had been organised so that when the practice experienced peak demand on Mondays there were always sufficient staff working. The practice had monitored patient demand on a daily basis and was prepared to meet patient expectations and plan appointment times and availability of GPs. We saw evidence in the planning of patient appointments with GPs and with nurses that the practice had responded to patients' health care needs. We observed one example of this when, during our visit, a patient presented at the practice without a pre-arranged appointment and was seen by a GP.

Medicines management

We saw that medicines to treat anaphylactic shock that were kept in readiness in each treatment room were within their use by date and had been regularly checked. We

Are services safe?

found that all vaccines were stored correctly and were within their use-by date. Temperatures for vaccines stored in fridges were recorded and had not exceeded the safe temperature range.

Cleanliness and infection control

The infection control policy had named a lead person responsible for prevention of cross infections. The infection control procedures included National Institute for Care and Health Excellence (NICE) guidelines, which were accessible to all staff.

Clinical waste was safely stored in suitable types of containers for the different types of waste, before being placed in larger locked containers in areas that were not used by the public. There was a licensed waste disposal company contracted by the surgery to collect this waste.

We observed that all parts of the premises were visibly clean and tidy, although some areas of the building were worn and in need of redecoration. Patient waiting areas were clean and there were suitably sited hand wash gels for use in patient waiting areas and in each GP or nurse consultation room. There was a daily cleaning schedule of all areas of the premises and there were suitable daily checks of the cleaning carried out by a contracted cleaner. We observed that cleaning equipment was safely stored and was colour coded for use in particular areas of the surgery.

Staffing and recruitment

The staffing establishment and their skills and level of qualification had been reviewed by the provider. We saw evidence of the written plan for providing staff numbers at the qualifications that were required by staff. One GP partner explained to us how staffing levels had been planned in response to patients' needs and how this was kept under permanent review. They informed us that this issue was always discussed at the partners' business meetings that were regularly held by the provider.

Dealing with Emergencies

The practice had a business continuity plan. The practice had arrangements to relocate the surgery in the event of a major incident.

Equipment

We found that patients were protected from the risks arising from the use of unsafe equipment because there were arrangements for checking such equipment. We saw test and calibration records for the AED, the vaccination fridge and thermometers that showed they had been checked regularly and were working correctly.

Fire safety equipment and alarms had been regularly checked for working order. Staff informed us they had been instructed about fire safety and evacuation and that they carried out weekly checks of the fire alarm to ensure that it was in working order.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs had been consistently met in a timely manner.

We saw a completed clinical audit cycle. The audit cycle we looked at assessed the improvements made in the way that patients were screened for cervical cancer.

There was an effective system in place to manage the health reviews of patients with long term conditions and there were effective working links with other health and social care providers. This was particularly the case in relation to people who were receiving care at the end of their lives.

We found that staff had access to the training they needed to carry out their roles effectively and were supported through annual appraisals.

Our findings

Promoting best practice

We saw that the practice had promoted the Gold Standards Framework for people nearing the end of life through the regular multi-disciplinary palliative care meetings that they had organised. Clinical meetings were held every month and involved all clinical staff on duty. During these meetings clinical audits were presented and discussed. Clinical audit is a process to improve patient care and outcomes through the systematic review of care and implementation and review of change. Significant events analysis and updates on best practice had been discussed at the clinical meetings.

Clinical staff we spoke with had a sound understanding of consent, the Mental Capacity Act (MCA) 2005 and use of the Gillick competency and the associated Fraser guidelines. The purpose of the Mental Capacity Act 2005 (MCA) is to empower people to make decisions wherever possible and to protect those who lack capacity by providing a flexible framework that places individuals at the heart of the decision making process. The Gillick competency and Fraser guidelines relates to contraceptive advice and treatment to under 16 year olds and generally whether a child has the competency to make decisions and understand the implications of that decision.

Management, monitoring and improving outcomes for people

According to West Lincolnshire Clinical Commissioning Group (CCG) data, Caskgate Street Surgery was performing well and did not present any quality risks. The practice had held regular meetings with the CCG to ensure that their performance was reviewed and their services were being suitably responsive according to demographic needs.

The practice was aware of its performance within its Clinical Commissioning Group area (CCG) and worked to improve this. At the time of our inspection the practice was in the upper quartile for Quality and Outcomes framework data (QOF). QOF is a voluntary incentive scheme for GPs in England.

The practice was proactive in choosing its most vulnerable groups and had also completed health reviews for all over 75 year olds and those with long term conditions and those

Are services effective?

(for example, treatment is effective)

on end of life care. All patients irrespective of their age had a named GP. Patients told us they valued this arrangement which most of them described as personal intervention in their care and treatment.

Staffing

We saw that the practice kept a check to ensure that their GPs and nurses were registered to practice. We also saw evidence of professional indemnity for all GPs.

Staff recruitment records revealed that appropriate identity checks, employment references and Disclosure and Barring Service (DBS) checks had been applied before staff commenced employment

Staff told us that they felt well supported. They told us if they needed any changes to their working practice they felt able to discuss this with the practice manager and GP partners. One member of nursing staff told us how they worked with other nurses to support each other and manage their list of patients.

The range of training undertaken by staff had ensured they were appropriately qualified and skilled. We were informed by one nurse that nurses were responsible for their own continuous professional development and that they identified most of the training they needed. We were told that all staff had received basic training in safeguarding children and vulnerable adults, health and safety and cardio pulmonary resuscitation (CPR). GP's annual appraisals had been completed and nurses were up to date with their continuous professional development and registration. We saw that the practice manager had completed a management qualification appropriate to their role.

Records confirmed that staff had received recent training for safeguarding children and vulnerable adults, equality and diversity, health and safety and information governance. We saw evidence that that a range of the training courses to meet staff learning needs had been arranged for staff for 2014 to 2015.

An effective appraisal process was being implemented. We saw that nurses had received regular annual appraisals from one of the GPs where learning opportunities were identified and discussed and arrangements put into place to meet learning needs. This process was being implemented for all other members of staff.

Working with other services

We found evidence that the practice worked alongside community nurses, health visitors and with Local Authority social care teams when necessary. We also saw that they had worked co-operatively with several residential care homes to ensure their care was effective within a multi-disciplinary approach that supported people with complex needs.

Effective palliative care planning had been established through collaborative working with hospices and community nurses, as well as involving relatives in patients and families in the decision making. This multidisciplinary treatment approach had been recorded in the care records. We also found that further collaborative working arrangements with mental health community teams and with the older persons' multi-disciplinary teams had been frequently been conducted by face to face meetings and through telephone contact with these health professionals.

One doctor we spoke with showed us evidence of how information about patients, who had a diagnosed mental health condition, was shared with Community Psychiatric Nurses (CPNs) and information about children at risk was shared with Health Visitors. We also saw how information about long term conditions and palliative care patients was regularly shared with community nursing teams.

Information provided from the out-of-hours GP services had been reviewed by the practice's duty GP as soon as the information arrived. Any action required was then allocated to the appropriate member of staff and this had ensured the practice had recorded the most up to date information about patient's health care and treatment. We also saw that the practice shared key information with the ambulance service about patients nearing the end of their lives.

Health, promotion and prevention

Health promotion was seen to take place through the regular appraisals conducted by the CCG and through the attainment of approximately 95% of the national average for all of the Quality Outcomes Framework indicators that apply to GPs in the UK through their General Medical Services contract.

We found that improving patient health was promoted via cessation smoking sessions. We saw evidence that GPs and nurses had discussed with patients, who were diabetic, how to manage their condition. We found evidence that

Are services effective?

(for example, treatment is effective)

patients who had experienced mental ill health, their physical health and lifestyle had been discussed with them and they had been offered advice and information about diet and the support networks that were available to them. We read details that showed that cervical cancer screening was up to date and was an improvement on the numbers of the previous screening programme.

We saw that the practice had a range of printed information available in the reception area relating to the promotion of good health and the prevention of ill-health, such as information about smoking, alcohol intake, diet and cancer. This meant that patients had access to suitable information to help them to understand risks to their health.

We asked the nursing staff about their childhood vaccination programme and found there was a robust system in place for following up those children who had not attended their vaccination appointments.

We were told by a GP that new patients were offered an appointment with a nurse or a GP. These appointments included an assessment of the patient and of any risk factors for developing long term conditions, for example, smoking, body mass index, blood pressure and family history.

We saw that patients with palliative care needs had been assessed and were regularly discussed and monitored at the monthly multi-disciplinary team meetings involving the doctors, the practice nurse, the community nursing team and the Macmillan service. The purpose of the monthly team meetings was to discuss each person and to make alterations to their care plan based on their evolving needs. We looked at the anonymised records of a number of these meetings and saw evidence of how this had worked. This had ensured that patients received care that met their particular needs and that their preferences about their death were acted on.

Are services caring?

Summary of findings

The practice was caring. We found that people were treated with dignity, respect and compassion. Patients spoke very positively of their experiences and of the care and attention offered by the staff. The sensitive and respectful attitudes and behaviour of the staff that we observed were reflected in patients' experiences.

Consent was obtained and care and treatment discussed with patients in order for them to make an informed decision.

Patients were involved in planning their care and treatment and patients receiving end of life care were provided with personal care by the GPs at the practice.

Our findings

Respect, dignity, compassion and empathy

We observed that patients were treated with respect and politeness when reception staff greeted them and when nurses and GPs greeted them. We noted that the administrative and reception staff were always mindful of speaking to patients in a manner that considered patient confidentiality and showed respect towards every patient. All of the 13 patients we spoke with said that they had always been treated with the utmost respect and shown kindness and attentiveness by everybody who worked at the practice.

We observed that telephone calls requiring privacy were conducted in an office away from patients and all staff told us that the practice regarded patient confidentiality as a priority.

We saw that there was information about support services for people who were caring for others. Those patients who were identified as carers were asked to complete a questionnaire and were given a specific assessment by one of the GPs. We were informed by one patient who was a carer, that they had been referred onwards to their local social care team. This showed that carers and those they were caring for received appropriate and compassionate support.

One patient reported in their comment card, that for patients with a hearing difficulty, the sound system for calling patients was not effective and told us that they would inform the reception staff about this.

Involvement in decisions and consent

We saw evidence that people had been included and had been offered choices and information about managing their conditions. People we spoke with told us they had been given advice and choices about their medication when this had been reviewed.

We found that the practice made appropriate, caring arrangements for patients receiving end of life care so that their preferences at the time of their death could be met. Information had been supplied to the out of hours service and the ambulance service about patients' wishes and decisions made about resuscitation. This meant that their preferences about their death could be fulfilled.

Are services caring?

Patients we spoke with told us they had always been treated in a manner that they felt satisfied with and could offer their opinions and views and had made choices about their health. We also found that patient's decisions had been recorded as part of their consultation and treatment notes. Some patients we spoke with added that they had been asked for and had given consent to examination. We read a consent policy that showed the practice promoted patients' rights to make decisions about their treatment.

We found that Gillick competencies framework was used to determine choices made by young people.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. There was a culture within the organisation that promoted listening to patients' views and opinions when they were seen by GPs or by nurses. We found that the practice had a good understanding of the demographic of its population and adjusted its resources to ensure patient's needs were met.

The complaints policy had ensured that people's issues had been listened to and responded to within appropriate timescales and that patients' suggestions had been acted upon.

The practice had initiated discussions with NHS England and with their Local Authority about ways to improve their services for their existing patients and for an anticipated increase in numbers of patients.

Our findings

Responding to and meeting people's needs

We saw evidence that the practice had a data system of patient diagnosis and had created a profile of patients' diagnoses, their ages and gender. We were informed the practice used this to discuss the prevalent age groups and the diagnosed needs of patients during practice meetings and at clinical governance meetings.

There was a selection of a range of languages that patients could refer to on the surgery's website. Reception staff informed us the surgery has access the use of interpreters, should the need arise.

There was information on the practice's website to inform patients the practice provided seasonal vaccinations and childhood immunisation and services for minor illnesses and pregnancy. There was other information and advice for long term conditions such as, asthma, diabetes, chronic heart disease, cancer and mental health.

We gathered information that the practice had not achieved the national average figure for completing health checks for people with severe mental illness. We found that patients with mental health problems had been monitored and that their physical health and their medication had been reviewed. The practice had contacted patients and ensured these reviews had taken place. However, we found that failures by patients to attend these appointments had counted for the difficulty to achieve national targets.

Access to the service

The opening hours were clearly sated by the practice and were shown on their website and in the practice leaflets that were available in the waiting area.

Patients we spoke with told us that they were satisfied with the appointment system to see the same GP each time the visited the surgery. They said they appreciated the regular contact with the same GP and the personal approach provided by the practice. We found that there were appointments for patients to see a duty doctor or a nurse if their appointment was urgent. This had ensured that all patients with urgent needs were seen on a daily basis.

Are services responsive to people's needs?

(for example, to feedback?)

We observed administrative staff who spoke to patients whenever they telephoned for an appointment. We noted that they did not discuss any clinical matters with them, but responded appropriately and arranged for them to see either a nurse, or a GP.

Some respondents to the patient survey, which was carried out by the practice, had suggested taking on another GP to reduce the waiting time for routine appointments. The practice had responded to this matter in the report they had published on their website. They acknowledged this potential action, but stated that the premises did not have adequate space for this to be accomplished and that they were continuing to look for a solution.

There was a wheelchair and pushchair ramp to the main entrance of the building. The reception staff told us that they were usually aware in advance of when someone with restricted mobility would be visiting the surgery and that patients would always be seen in a ground floor surgery, if this was necessary.

The continual monitoring of the appointment system and the staffing levels had ensured that patient need was being measured and managed by the practice, so that all patients were seen in a timely and well managed approach. The surgery had initiated discussions with NHS England and with their Local Authority about ways to improve their services for their existing patients and for an anticipated increase in numbers of patients.

Concerns and complaints

We saw that there was a clear complaints policy on display in the practice and also on the practice website. People told us they would know how to complain if necessary, but that they had never had cause to do so.

We viewed the practice's complaints procedure and the practice manager talked us through the stages of the process once a complaint had been made. We found that there was a system in place for handling complaints. We saw evidence that complaints had been recorded in detail and had been responded to in a timely and polite manner and had been acted on when this was possible and appropriate. Staff told us that they had learnt from complaints that had been analysed and this had led to them making changes to their telephone answering skills and their manner of communication with patients.

Are services well-led?

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

Summary of findings

The practice was well led. The partner leadership team had a vision and a purpose for improving their service. Staff were supported in regard to their welfare and were supported and encouraged by GPs through formal clinical meetings and through less formal daily support when this was required.

The culture of the practice was open and staff told us they felt empowered to report any concerns or to make suggestions for improvement. Staff were encouraged to take ownership of their responsibilities.

There was a strong focus on improving quality of care through learning. This was evident across all staff groups within the practice.

The practice was supportive of patients' views. Members of the patient participation group (PPG) told us that they felt supported and listened to.

Our findings

Leadership and culture

The practice had a leadership ethos of wanting to provide a named GP for each patient and this was understood by all staff and by each of the 13 patients that we spoke with. All of the 13 patients we spoke with told us that they liked this arrangement because they had continuity of one doctor and that this was generally kept to whenever they attended the surgery.

Leadership roles for the management of the practice were shared between the GP partners and other staff. There were named leads of areas such as safeguarding, infection control and complaints. This ensured that staff were clear of their accountabilities and knew who they should go to for support.

One nurse told us that the nurse staff were always able to approach a GP at any time for assistance during surgery hours. They said that GPs provided clinical support at any time should they require support. We were told that there were informal, daily arrangements for clinical discussion, as well as regular practice meetings and clinical governance training meetings to ensure clinical support is provided.

Leadership roles for the management of the practice were shared between the GP partners and other staff.

Governance arrangements

Governance arrangements at the practice were clear. Staff knew what they were accountable for, as individuals and as teams and the policies and procedures for the practice supported this. The practice had specific and designated lead roles for different aspects of the practice's business, such as a safeguarding lead and infection control lead.

We saw that incidents and complaints had been discussed at staff meetings and clinical governance meetings. Staff we spoke with demonstrated that they had improved their service as a result of the investigation process. The minutes of the monthly clinical meetings and the weekly practice meetings provided evidence that clinical issues and surgery wide matters for all staff had been discussed and considered by the surgery.

Staff had received training in information governance. Access to clinical notes was restricted to those staff who

Are services well-led?

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

needed it. We saw that the codes used within the surgery IT system to identify certain types of patients, for example, those who had had mental ill-health matter, were accurate. This showed that data quality standards were high.

The practice's monthly clinical meetings had reviewed the quality of care provided to ensure that it was patient focussed. We saw that patient demands and numbers seen by the surgery had been monitored and this had resulted in a clear method and system put in place to ensure that patients' daily needs had been met by sufficient numbers of skilled clinical staff.

The practice had systems in place to identify and manage the risks to patients associated with the level of staffing and their skill.

Systems to monitor and improve quality and improvement

Staff met regularly at the practice meetings. They told us this had promoted a strong team feeling and a clear understanding of the support, training they expected. Staff also reported that they felt supported by an open door management approach that gave them opportunities to discuss professional and personal support and welfare issues.

Meetings the practice had with other providers, such as the health visitors and palliative care teams and care homes, had resulted in care being given in patients best interests. We saw an example of how this was achieved when one patient wanted to move into a care home.

Patient experience and involvement

We saw that last two years patient surveys conducted by the practice were posted on the surgery website and that the surveys were extensive and included questions that incorporate the General Practice Assessments Questionnaire (GPAQ), a Primary Care Assessment Survey developed by Manchester and Cambridge Universities. Questions were related to GPs attitudes and conduct and patients were asked for suggestions they might like to make. Results indicated a high rate of patient satisfaction.

The practice had an active patient participation group (PPG), which met periodically with the surgery. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. Representatives of the group, who we met with during the inspection, told us that they were listened to by the practice and that the practice had responded to some of their suggestions, such as keeping a named GP for patients. This showed that the practice had processes in place for engaging with people using the service and for acting on their feedback.

We found that the practice had responded to patients comments about improvements to patient confidentiality when dealing with reception staff and had acknowledged and considered improvements they would like to make. The surgery's response report was published on their website.

We found that there was information on the website and in the practice about the NHS Care Data programme for the potential to share health information with other healthcare providers, for improved patient outcomes. We saw that the practice had provided a clear explanation and had shown that patients can make a choice about agreeing to this proposal.

The 12 patient comment cards that we received showed that each patient had a very positive experience whenever they had attended the surgery and that the highest compliments were for the attitude and kindness shown by all staff.

Staff engagement and involvement

Staff members we spoke with told us that they felt valued by all of the senior team at the practice and that their views were listened to. This included the practice manager's 'open door' policy to discuss any areas of concern or suggestions at any time. We also saw evidence that there was an effective whistleblowing policy in place.

Learning and improvement

Staff told us that they could contribute their views to the running of the practice and that they felt they worked well together as part of the practice team to ensure they continued to deliver good quality care.

The practice held regular monthly training sessions for all their staff in order to improve their service. These training sessions had included topics such as, confidentiality and respiratory diseases. The weekly practice meetings and monthly clinical governance meetings had been used to improve and sustain the quality of the service. These meeting were used as learning sets and as opportunities for nurses to learn from GPs. We found that one nurse had been supported to study for a Diploma in sexual health in order to improve the services offered by the surgery.

Are services well-led?

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

We saw evidence that there were effective arrangements in place to manage staff performance through annual appraisals.

Identification and management of risk

The practice worked proactively with external agencies to ensure that staff recruitment and the surgery's development identified and mitigated any risks before they happened. The practice had identified a risk related to the increase in numbers of their patient population. One of the partner GPs explained how the surgery had planned to meet this growing demand and had been in discussion with the local authority around the proposed infrastructure of a planned new build site nearby and how the practice could fit in with this infrastructure.

The practice manager demonstrated that they monitored the provision and arrangements for cervical smear testing, vaccinations and this had ensured that any issues were identified in a timely manner.