Kidgate Surgery

Quality Report

32 Queen Street, Louth LN11 9AU
Tel: 01507 602421
Website: www.thekidgatesurgery.co.uk

Date of inspection visit: 21 October 2014
Date of publication: 05/02/2015

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

Ratings

Overall rating for this service	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 8

Areas for improvement 8

Detailed findings from this inspection

Our inspection team 9

Background to Kidgate Surgery 9

Why we carried out this inspection 9

How we carried out this inspection 9

Detailed findings 11

Action we have told the provider to take 20

Overall summary

Letter from the Chief Inspector of General Practice

Kidgate Surgery offers a range of primary medical services from a single location at 32 Queen Street Louth, Lincolnshire, LN11 9AU

We carried out an announced, comprehensive inspection on 21 October 2014.

Prior to our inspection we consulted with the local clinical commissioning group (CCG) and the NHS local area team about the practice. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. Neither of these organisations had any significant concerns.

We spoke with patients and staff including the management team. The inspection focussed on whether the care and treatment of patients was safe, effective, caring, responsive and well led.

During the inspection we spoke with patients and carers that used the practice and met with members of the patient participation group (PPG). A PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We also reviewed comments cards that had been provided by CQC on which patients could record their views.

We looked at patient care across the following population groups: Older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health.

Our key findings were as follows:

- Patients were treated by caring GPs and staff who demonstrated compassion, dignity and respect.

Summary of findings

- Patients were positive about their experience of using the practice which had scored highly in the NHS Patient Survey.
- Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.
- Staff understood their responsibilities to raise concerns, and report incidents and near misses.
- Patients reported good access to the practice, a named GP and continuity of care. Urgent appointments were available the same day.

The overall rating for Kidgate Surgery is 'Good'. However there are some issues that the practice should address;

Importantly the provider must;

- Ensure that all clinical staff receive training on infection prevention and control.
- Ensure that infection prevention and control audits are undertaken to help protect patients, staff and others from the risk of healthcare associated infections.
- Undertake regular audits of cleaning to help ensure patient safety.
- Ensure that all staff are provided with fire safety training.

In addition the provider should;

- Review its policies and protocols to ensure they are up to date and relevant.
- Develop the patient participation group.
- Undertake local surveys of patients as a means of assessing and monitoring the quality of service provision.
- Consider installing a means of staff summoning assistance to the treatment room in the event of a medical emergency or if a patient became violent or aggressive.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. We found that there had been no infection prevention and control audits and there was no evidence that all staff had received training in this subject area. No audits on the effectiveness of the cleaning of the surgery had been conducted and not all staff has received training in fire safety.

There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure

Summary of findings

improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. However we found that some policies were overdue review and required up-dating. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on, although the practice should undertake surveys of patients at a local level to gather their views. The practice had a patient participation group although it was not promoted either in the practice information leaflet or website. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours. We saw good examples of joint working with midwives and health visitors.

Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability .It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had helped people with poor mental health to access other support.

Summary of findings

What people who use the service say

During the inspection we talked with four patients. They told us that the care and treatment they received was good and that they felt fully informed as to their treatment options

Both the patients we talked with, and the patients who had completed 17 CQC comments cards, said that they were treated with dignity and respect and that they felt fully involved in decisions about their healthcare. Several of the respondents had emphasised the friendly and caring attitude of GPs and staff.

Patients told us that getting an appointment to see a GP was straightforward and some said how they appreciated the personal touch displayed by GPs who they had known for many years.

Data taken form the NHS patient survey showed that 98.76% of patients felt that their overall experience was good or very good.

Areas for improvement

Action the service MUST take to improve

- Ensure that all clinical staff receive training on infection prevention and control.
- Ensure that infection prevention and control audits are undertaken to help protect patients, staff and others from the risk of healthcare associated infections.
- Undertake regular audits of cleaning to help ensure patient safety.
- Ensure that all staff are provided with fire safety training.

Action the service SHOULD take to improve

- Review its policies and protocols to ensure they are up to date and relevant.
- Develop the patient participation group.
- Undertake local surveys of patients as a means of assessing and monitoring the quality of service provision.
- Consider installing a means of staff summoning assistance to the treatment room in the event of a medical emergency or if a patient became violent or aggressive.

Kidgate Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included a practice manager.

Background to Kidgate Surgery

The practice is located in a former health centre in the market town of Louth. On the day of our inspection the patient list was approximately 3,800.

The surgery has a small car park and is located immediately adjacent to a public car park. There is good access for people with mobility issues.

The practice is within the area covered by Lincolnshire East Clinical Commissioning Group. The practice has opted out of the requirement to provide GP services outside of normal hours. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust Out of Hours Service.

The practice patient list contains a high percentage of patients aged 65 years or over compared with the national average. There was high incidence of disability allowance claimants and more than twice the average number of patients in nursing homes as compared to national averages.

The practice has two whole time equivalent GP partners and one long term locum GP. Two practice nurses, one phlebotomist/ dispenser and three dispensers are employed, together with receptionists and administration staff.

The practice operates a dispensary for the benefit of patients who are eligible by virtue of the distance they lived from the surgery.

The practice is registered with the Care Quality Commission to provide the regulated activities of; the treatment of disease, disorder and injury; diagnostic and screening procedures; family planning; maternity and midwifery services and surgical procedures.

The surgery was open from 8.30 am until 6.30 pm daily, with extended opening hours on one evening a week until 8pm. GP consultations were available from 9 am to12 noon and 4 pm to 6 pm.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. These groups are:

• Older people

• People with long-term conditions

• Families, children and young people

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

• People whose circumstances may make them vulnerable

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

Before visiting, we reviewed a range of information that we hold about the practice.

We carried out an announced visit on 21 October 2014. During our visit we spoke with a range of staff including GPs, a nurse, dispensary staff, reception and administration staff. We spoke with patients who used the service. We observed the interactions between patients and staff, and talked with carers and family members. We met with two representatives of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We reviewed 17 CQC comment cards where patients had shared their views and experiences of the service.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We also reviewed information we had received from Healthwatch, NHS Choices and other publically accessible information.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw details of how the practice had dealt with an aggressive partner of a patient.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. For example we saw details regarding a minor accident that had occurred in the practice car park and how the practice had responded to the concerns.

We looked at significant events log and saw that detailed analysis had been undertaken to identify any learning from the recorded incidents and that these had been cascaded to staff.

National patient safety alerts were disseminated by the practice manger to staff. Staff we spoke with were able to give examples of recent alerts, for example the Ebola outbreak in West Africa, that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies.

The GPs were leads in safeguarding vulnerable adults and children. They had the necessary training to enable them to fulfil this role.Staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy, which was visible on the waiting room noticeboard. Staff had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, receptionists and dispensary staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements

because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. We saw evidence that an audit of their procedures had been carried out by an external auditor and the practice had adopted the recommendations contained in the report.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for people to pick up their dispensed prescriptions and had systems in place to monitor how these medicines were collected, for example establishing the identity of the person collecting the prescription. They also had arrangements in place to ensure that people collecting medicines from these locations were given all the relevant information they required.

Repeat prescriptions could be ordered on-line which aided working patients who might not be able to attend the surgery during normal working hours.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. However the practice was unable to produce any evidence that they were checking upon the efficacy of the cleaning regime by means of regular audit.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy but there was no evidence to show that they been enabled and carry out staff training. Although we were provided with evidence to show that non-clinical staff had received training in infection prevention and control there was no such evidence to show that clinical staff had received training.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. However we saw that this policy was dated 2003 and there was no evidence that it had been reviewed and updated. We asked to see infection prevention and control audits, but none could be produced.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. The practice used single use instruments only.

Notices about hand hygiene techniques were displayed. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available.

We looked at the procedures adopted when patients handed in samples at reception and saw that they were effective in staff avoiding handling the samples.

The practice had a policy for the management, testing and investigation of legionella (a bacteria that can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment.

Staffing and recruitment

Requires improvement

Are services safe?

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Risk was assessed and mitigating actions recorded to reduce and manage the risk. For example, the practice manager had shared the recent findings from a fire risk audit with the team and we saw the measures that had been taken in response to that audit.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

During our visit a medical emergency occurred that was dealt with effectively and efficiently by one of the GPs and the practice nurse.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of IT services, adverse weather, epidemic and pandemic.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety and we saw that these had been implemented. Records showed that some staff had completed fire safety training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes and chronic pulmonary obstructive disease and also had special interests in obstetrics, paediatrics and child psychiatry. The practice nurses supported this work, with nurses having undertaken specialised training, for example, in caring for people with diabetes. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions.

All patients over the age of 75 had a named GP.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken into the leg ulcer care, dermatology referrals, chronic obstructive pulmonary disease and the two week referral rate to secondary care for cancer diagnosis. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The GPs told us clinical audits were often linked to medicines management information, safety alerts, at the request of the CCG, or as a result of information from the quality, and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw that audit had been carried out at the request of the CCG into the prescribing rates for blood glucose test strips.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease .This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had achieved and implemented the gold standards framework for end of life care. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with them having special interests in obstetrics, paediatrics and child psychiatry. All GPs were up to date with their yearly continuing

Good

Are services effective?

(for example, treatment is effective)

professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties, for example, the administration of vaccines, cervical cytology and anti-coagulation. Those with extended roles for example seeing patients with long-term conditions such as diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. In the absence of the GP who had asked for the tests and investigations, another GP ensured that the appropriate action was taken. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. GPs commented however that since health visitors who had been based in the surgery had been removed to a central location, the service provide by them was not as good.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, SystmOne, to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

We saw evidence that staff had received training in consent issues.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing.

Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered NHS Health Checks to all its patients aged 40-74.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check.

The practice employed a member of staff whose role it was to identify and recall for review patients with long term conditions such as diabetes and asthma. We saw that this member of staff tried to ensure patients with multiple or co-morbidities only received one recall letter and that upon attending the surgery all their healthcare needs were addressed at one appointment. At the end of each month, checks were carried out to establish who had or had not attended their appointments. For those who had not attended two more letters could be sent to remind patients to make their review appointments.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good, with 93.6% saying they would recommend the practice. The practice was also rated highly for its satisfaction scores on consultations with doctors and nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were not provided in one of the treatment rooms we saw but a nurse told us that patient privacy was maintained as the door was locked when patients were receiving treatment. We saw that this room did not contain a telephone or any other means of summoning assistance, for example in the case of a medical emergency or if a patient became violent.

We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. All staff had received training in confidentiality, consent and information governance. Reception staff had received training specific to their role in customer care.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed that practice respondents said the GP involved them in care decisions and felt the GP was good at explaining treatment and results. Both these results were above average compared to the national average.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website informed people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that if families had suffered a bereavement, their usual GP contacted them and carried out a bereavement visit.This enabled the GP to offer them advice on how to find a support service. The bereaved family was always sent a condolence letter from the practice. We saw that a list of recently deceased patients was displayed in an area out of public gaze, to allow staff to be aware of recent deaths and to enable them to respond appropriately to relatives and carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were well understood and systems were in place to address identified needs in the way services were delivered. GPs displayed an extensive knowledge of their patients and their healthcare and social needs and this was reflected in the views and comments we received from patients.

The NHS Area Team and Clinical Commissioning Group told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

We were told that the practice had very few travellers who were patients and very occasionally they saw homeless people and those of no fixed abode. Another GP practice in Louth held special clinics for patients involved in drugs misuse and patients of Kidgate Surgery would normally be referred there for more specialised advice and assistance.

The practice provided equality and diversity training to staff and that was confirmed by those staff we spoke with.

The whole of the surgery was situated in a single story building. This made movement around the practice easier and helped to maintain patients' independence. We noted however that the entrance doors to the surgery were not automatic and were very heavy, making it difficult for wheelchair users to access the building un-aided. We raised this with one of the GPs who told us that patients trying to access the building were visible to reception staff who would assist them.

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

The practice had a very small number of patients whose English speaking skills were limited. Translation services were available to those patients if required.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for instance in the patient waiting room and in the practice information leaflet.

We looked at complaints received in the last 12 months and found they had been satisfactorily handled, dealt with in a timely way and with openness and transparency .

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. These values were clearly displayed in the practice information booklet.

We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 13 of these policies and procedures and found that one was dated 1994 and there was no evidence that this and some others had been reviewed to ensure they were still relevant.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the partners was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Leadership, openness and transparency

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We were told by staff that a former member of staff who had recently died left money in her will so that the staff at the practice could have a night out.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. We were shown the staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the NHS patient surveys and complaints received. We looked at the results of the patient survey and saw that respondents had rated the practice very highly in all areas surveyed.

We were told that the practice had taken part in the pilot scheme for the 'Family and Friends' initiative in 2012/13 and that the comments from patients were positive but no detailed results were made available to us.

The practice had a patient participation group (PPG), however we noted that there was no information about the group on either the practice website or in the practice information booklet, although information about the group was clearly displayed in the patient waiting area. There was no evidence of the group having carried out any patient surveys or the group being influential in shaping the nature of the services provided at the practice.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example we saw that the learning derived from incidents with aggressive and violent patients had been cascaded to staff.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 (2)(a) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010** **People who use the service and others were not protected against identifiable risks of acquiring healthcare associated infections by the effective operation of systems designed to assess the risk of, and to prevent, detect and control the spread of a health care associated infection.**