Duke Street Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Duke Street in situated in the city centre of Barrow in a Victorian built building it has six GPs, a practice manager, a nurse practioner, a clinical lead, a team of nurses and health care assistants who were supported by receptionists and administration support teams. They provide primary care services for patients in the area of Barrow and its immediate vicinity which included those working offshore.

Patients we spoke with told us they were happy with the care and treatment they received and they always felt safe. We saw evidence of robust systems in place which helped ensure patient safety by learning from incidents and good infection prevention and control.

The provider had taken robust steps to ensure all staff went through a rigorous recruitment and induction process which helped them to provide suitable care for their patients.

We spoke with members of staff who were positive about the management and leadership team and felt supported in their roles. They said they were approachable and listened to suggestions to improve the service provided to their 9,300 patients. The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities:- Diagnostic and Screening, Family Planning, Maternity and midwifery services, Treatment of disease, disorder and injury and Surgical Procedures.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
Overall the service was safe.

Patients were protected from harm and abuse because suitable policies and procedures were in place, which enabled them to recognise and act on any event or incident and lessons learned were shared with all staff. The provider had systems in place to safeguard vulnerable patients from the risk of harm.

Are services effective?
Overall the service was effective.

Care and treatment was delivered in line with best practice guidelines. Clinicians were able to prioritise patients and make use of available resources. We found there was no untoward comments from the current commissioner of care and services offered by the practice

Are services caring?
Overall the service was caring.

Patients who we spoke with who used the service were generally positive of their experience when they used Duke Street Surgery. We found the practice provided effective care to a wide range of patients who had differing needs. Patients thought the staff were friendly who cared for and responded to their needs. We saw good interaction between patients and staff and the staff treated patients with respect and protected their dignity and confidentiality.

Are services responsive to people's needs?
Overall the service was responsive to people's needs.

There was an open culture within the organisation and a comprehensive complaints policy. Complaints about the service and significant events were taken seriously and were responded to in a timely manner. We saw patient and staff suggestions for making improvements had been acted on. The provider was always seeking ways to improve the services offered. Although we noted there was some concern from some patients we spoke with about access to appointments.

Are services well-led?
Overall the service was well-led.

The members of staff we spoke with spoke highly of the leadership qualities of the partners and the management team. There was a

Summary of findings

visible leadership team with vision and purpose. Structures were robust and there were systems in place for managing risk. The provider welcomed challenge and promoted an open and fair culture.

Summary of findings

The six population groups and what we found

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

Summary of findings

What people who use the service say

We spoke with 11 patients who used the service and generally their comments were positive. They said the staff treated them with respect and dignity. However patients did state their views over having to wait for long periods to get appointments and some patients thought there was only two occasions during the day they could ring to book an appointment. Other patients were happy as they telephoned the surgery and got a same day appointment. Patients could get repeat prescriptions and book online appointments up to four weeks in advance. We looked at the results of the Duke Street Surgeries yearly patient participation group survey held since January 2014, generally the results were positive and showed a positive attitude towards the provider and the service they provided. Ninety-one per cent thought the opening times were convenient and almost all patients thought it was easy to get an appointment at a time that suited them. Comments included they thought it was also important to see the GP of their choice.

Comments cards had been left by the CQC to enable patients to record their views on the service. However we found there were no completed comments cards in the CQC comments box.

Areas for improvement

Action the service COULD take to improve

To revisit the chaperone policy for the practice.

Duke Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was made up of an expert by experience, a GP and two CQC inspectors who led the inspection.

Background to Duke Street Surgery

Duke Street Surgery is situated in the town of Barrow this was a shipbuilding town with a high level of unemployment as a result of a decline in industry. The service is responsible for providing primary care for approximately 9,500 patients and offers a wide range of specialist clinics and services providing advice and support on a number of healthcare issues.

After normal practice hours which are 8:15am to 6pm except on Wednesdays and Fridays when they open from 7:30am to 6pm there is an out of hours service Cumbria Health on Call (CHOC) which provides cover for the practice. Duke Street surgery covers the town of Barrow and its nearby vicinity. The provider reports to the Cumbria Clinical Commissioning Group.

They also allowed military personnel located nearby to use their premises for the benefit of their personnel but they were tended to by their own military medical clinicians. The service at Duke Street provides a telephone triage medical advice for callers and face to face consultations with doctors and nurses.

Why we carried out this inspection

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

How we carried out this inspection

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?

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 7 May 2014. During our visit we conducted a tour of the premises. We also spoke with a range of staff which included GPs at the practice, the registered manager, the practice manager, receptionists, nurses and spoke with 11 patients who used the service. We observed how people were being cared for and talked with patients. There was a virtual online Patient Participation Group (PPG). We reviewed information which had been provided by the provider and looked at the practice's policies, procedures and some audits. We reviewed other information that was available in the public domain such as their website and NHS choices website.

Are services safe?

Summary of findings

Overall the service was safe.Patients were protected from harm and abuse because suitable policies and procedures were in place, which enabled them to recognise and act on any event or incident and lessons learned were shared with all staff. The provider had systems in place to safeguard vulnerable patients from the risk of harm.

Our findings

Safe Patient Care

We spoke with patients who used the service who told us they felt safe and trusted the GPs and nurses. They did not raise any concerns about their safety. We did not receive any concerns from NHS England regarding safety of the practice.

We saw the provider had a procedure for the recruitment of staff. Checks were undertaken of GPs and nurses with their respective registration bodies General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). We spoke with the practice manager who told us of the process which ensured clinical staff continued to be registered with the GMC and NMC.

There were effective arrangements in place for reporting safety incidents and allegations of abuse which were in line with national and statutory guidance.

There were clear accountabilities for incident reporting, and staff we spoke with could describe their role in the reporting process. Information regarding outcomes from any incidents or occurrences were cascaded to staff via staff meetings.

We saw the practice was accessible for people with restricted mobility for example a wheelchair and the areas for patient accessibility were adequate.

Learning from incidents

We saw evidence of how the practice had dealt with complaints and other significant events. We saw how people had been updated and kept informed of the progress on the incident. We were told by staff how this had been discussed at staff meetings in order to gain information from lessons learned. This included also learning from external incidents as well as internal incidents.

We reviewed how the practice managed serious or significant incidents. Records showed the system in place was managed in line with guidance issued by the national patient safety agency. The practice carried out audits of their significant event.

We looked at examples of audits carried out at the practice and found where necessary a more robust investigation (root cause analysis) was carried out. Findings and improvements necessary from significant events were

cascaded to staff via training and staff meetings. The staff we spoke with at the practice told us they were encouraged to raise concerns and had received feedback from any incidents they reported. The provider showed us where necessary patients were also informed of the outcomes of the incident.

Safeguarding

We spoke with staff about the safeguarding of vulnerable adults and children. All the staff knew what to do and who to report it to and who the leads at the practice were for vulnerable adults and children. We saw evidence of who staff should contact and this was stored on the practices computer system, this included the local authority safeguarding board. Staff spoke knowledgeably about safeguarding and explained in detail what they would do if they had any concerns.

The surgery followed national guidance regarding safeguarding and all the GPs had recently been updated in their training provided locally by the CCG. Other practice staff were trained to an appropriate level for their role. One of the GPs was the lead on safeguarding for the practice. There was also a GP locality lead within the CCG who acted as another source of contact should this be required by staff at the surgery. At risk children were discussed in regular Multi-Disciplinary Team (MDT) meetings attended by the health visitors.

Monitoring Safety & Responding to Risk

We saw evidence the provider had in place procedures to deal with significant events. We saw how the clinical and non clinical incidents had been reported and recorded this included examples of the interruption of the electricity supply to the fridge, an abusive patient and how the wrong patient was visited. We saw there had been appropriate investigations and actions taken to prevent reoccurrences. We saw evidence of how the provider shared this information with staff members at their weekly team meetings, which staff found very useful and a good way to learn.

The practice significant event analysis folder was reviewed. All cases we looked at included details of the event, why it happened, learning points and changes to current practice. The clinicians undertook discussions of clinical significant events and tried to learn from outcomes. An example of this was when a patient that was treated for a suspected urinary tract infection by a GP but was unable to provide a urine sample, they later took a sample to a Health Care Assistant that had a trace of blood, though this was not flagged up at the time. As a result of this, the practice has now changed and there is now a protocol for dealing with urine samples that demonstrate traces of blood.

We spoke with staff and we saw evidence that staff had been trained in how to deal with medical emergencies which included resuscitation. This showed to us that patients could be assured knowing that if there was a medical emergency the provider had sufficiently trained staff to deal with the situation.

We spoke with the GP who was the registered manager and the practice manager who knew of their requirements to notify CQC this included any changes, certain events and incidents which would affect the service. We found the practice manager r was aware of these requirements and had previously notified the CQC of changes. We found that the practice ensured that the clinical staff received annual cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis shock. Staff trained to use the defibrillator received regular update training to ensure they remained competent in its use.

Medicines Management

The amounts of medicines stored were monitored and we saw evidence they were checked for their expiry dates which ensured their effectiveness. We checked the fridges and fridge temperatures and saw evidence of the recording of the temperatures (twice) on an everyday basis.

All drugs were locked in suitable cabinets in accordance with guidelines. The fridge had a chip/date logger which recorded information around any faults for example if the fridge stopped working the time and date was recorded. However there was no record of the medicines held. We spoke with a nurse who stated that staff rotated correctly the medicines, which were ordered when the stock was running low. There were no formal checks or stock control systems in place.

We checked the emergency drugs, defibrillator and oxygen. We were told these were checked on a regular basis and these checks were recorded. There were no controlled drugs held on the premises.

Are services safe?

Cleanliness & Infection Control

We observed that all areas of the practice were visibly clean and no discernable odours The patient waiting areas were adequate. We toured the premises and saw everything in the consulting rooms was clean and well cared for. This included the furniture and the consultation couches.

We looked at five consulting rooms. We saw wall mounted hand sanitising liquids were located close to the sinks and pictorial information which promoted good hand hygiene.

There were sufficient quantities of gloves and aprons and the consulting couches had paper rolls protecting them. However staff could not show us where the spillage kits were located which should have been available to deal with any spillage of body fluids such as blood or urine. There were appropriate procedures in place to protect staff and patients from dangers associated with sharps. The sharps bins were stored suitably out of the reach of children.

We spoke with staff who told us they were trained in infection control. We saw evidence of some audits in infection prevention and control. We spoke with the practice manager who stated they were reviewing how they recorded the audits after staff had suggested recommendations which would improve the system This included a daily audit checklist on display in each room so the clinicians were aware of what and when it had been cleaned last. We saw evidence of how and when the clinical waste was disposed of. We also saw evidence of the cleaning schedule which was followed by the cleaners.

We spoke with staff on reception and asked how they dealt with samples brought in by the patients. Members of staff told us they did not require personal protective equipment (PPE) as they did not touch the samples. They asked the patient to place them into sealed bags and then staff took them to a suitable storage container where the samples would be deposited. Staff did have access to PPE if they needed it, plus there were sufficient supplies of hand sanitiser at reception and on the walls close to reception for anyone who had deposited samples. However there was no spillage kit to be found. We discussed this with the practice manager who arranged for one to be ordered as soon as possible.

Staffing & Recruitment

We saw evidence of references being requested plus CVs and evidence of identity. We spoke with the practice manager who told us any notes from interviews were retained but then destroyed in line with current guidelines. Staff we spoke with thought the recruitment process was thorough and staff thought there was sufficient staff for the practice.

All staff were subject to checks to ensure they were suitable to work with vulnerable people. We saw evidence of relevant induction programmes for staff. We spoke with staff about their induction courses which they said they had completed. They said they had been shadowed by other members of staff and how a buddy system had been introduced to make staff feel more comfortable. However we found that while the competencies had been completed these had not been recorded anywhere. This was discussed with the practice manager who agreed to rectify this immediately.

Dealing with emergencies

We spoke with staff and we saw evidence that staff had been trained in how to deal with medical emergencies which included resuscitation. This showed to us that patients could be assured if there was a medical emergency the provider had sufficient trained staff to deal with the particular situation. There were robust plans in place to deal with emergencies that might interrupt the smooth running of the service such as power cuts and adverse weather conditions.

Equipment

Suitable medical equipment was in place. We saw that this had been properly serviced and the equipment was accessible and stored safely. Staff had received documented training in order to be able to use the equipment at the practice.

The practice had contracts in place to ensure safety checks of equipment such as firefighting equipment and the calibration of medical equipment.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective.Care and treatment was delivered in line with best practice guidelines. Clinicians were able to prioritise patients and make use of available resources. We found there was no untoward comments from the current commissioner of care and services offered by the practice

Our findings

Promoting best practice

1. Guidance existed for the management of chronic health conditions. This was usually led by the practice nurses who were the principal clinicians involved with the care of these patients.
2. We saw further examples where chronic health management was in accordance with NICE guidelines. One patient used a large number of tablets for pain relief but according to the GP we spoke with there was no documentation of protection of the gastro system being offered. However we were told there was good evidence of appropriate renal monitoring of a patient who had commenced using medication used for high blood pressure and congestive heart failure.

Managing, monitoring and improving outcome for people

We discussed with the GP principles around patients who presented with capacity issues. The GP told us of an occasion where a patient with impaired Mental Capacity had to be treated on best interest grounds as at that time they lacked capacity to refuse treatment.

The surgery undertook a telephone triage of all emergency calls from the patients. They then either performed home visits when necessary or the patient attended at the surgery for an appointment.

We reviewed the practice's Gold Standard Framework for palliative patients. This currently listed 20 patients which in a practice with a list size of 9,500 was lower than might be expected. This may be due to patients who had not presented to their GP with symptoms in order to be referred for the relevant investigation. We discussed this with the lead GP, they explained that the practice's high exception reporting rate in the Quality Outcome Framework (QOF) was due to patients who failed to attend for chronic health reviews despite numerous attempts by the practice to engage with them. This was particularly the case with patients who had not responded to invitations to attend for formal asthma reviews.

Staffing

We saw evidence of and staff confirmed they received an annual appraisal which enabled them to discuss their performance and plan for future objectives. We also saw the provider's appraisal and personal development plan

Are services effective?

(for example, treatment is effective)

policy which was comprehensive. The provider supported clinical and non clinical staff and provided training opportunities which aimed at providing safe care and treatment to patients. Staff we spoke with felt they worked for a good and supportive provider. However we did note from the training matrix that when staff had completed their courses they were not always recorded and some staff kept hold of their training records where others were recorded on the computer. Some of this learning would be online and there was evidence of how this would support the clinical staff in their own accreditation as well as non clinical staff in their mandatory training. We discussed this with the practice manager who had already started to address this and was working to ensure that the computer records were up to date and that competency records needed to be recorded.

Each individual GP was responsible for ensuring they met the requirements for annual appraisal and revalidation. Training was delivered periodically to a number of GPs on a local level to cover topics such as safeguarding. There was time allocated for an education focus within their practice meetings. This had included previously the invitation of a Consultant to speak to the practice on a cardiology topic.

Duke Street surgery was a training practice that takes from time to time a mixture of third and fourth year medical students from a nearby university; Foundation Year 2 (F2) doctors and GP registrars. There was currently no fully accredited GP Trainer within the practice though one of the GPs was in the process of gaining trainer accreditation. GPs had study time allocated for appropriate Continuous Personal Development (CPD) activities. However, it was noted that service commitments meant that it was not always practical to take CPD time to suit them.

Patients were cared for by suitably qualified skilled and experienced staff. The provider had completed relevant checks before staff started work. There was a recruitment and selection policy which the provider used when they recruited new staff. We spoke with members of staff who confirmed they completed an induction course and they held a copy of their Criminal Record Bureau (CRB) although we did not see evidence of these. We discussed with the practice manager about retaining either copies of their CRB checks or evidence of the serial number of the Disclosure and Barring Service (DBS) which the practice manager agreed to include in the checklist of people who will be recruited in the future. CRB and DBS checks ensured and identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable adults and children. We also saw information was obtained which confirmed the General Medical Council (GMC) registration of the GPs who worked at the surgery and the nurse's registrations with the Nursing and Midwifery Council (NMC). We randomly checked GPs and nurses on the GMC and/or NMC register and found their registration to be correct. Continuous Professional Development was provided for staff to help them maintain their professional registration and also to assist in their professional and personal development.

Working with other services.

We saw GPs referred patients for hospital treatment, where they used the standard Choose and Book guidance and were aware of and utilised referral criteria appropriately (e.g. for minor surgical procedures). There was a Single Point of Access referral mechanism used which assessed patient rehabilitation needs for extra support that was required at home (e.g. physiotherapy) for frail elderly patients at high risk of admission.

GPs completed care plans which were made available for Out Of Hours (OOH) providers. This gave instructions for how to deal with complex/ frail/ palliative patients. We were told that the OOH provider could access the last 3 consultations on the GP computer record and that this helped to aid the management of acute illness. Following an OOH contact the GP received an electronic copy of the patient consultation with the OOH provider and it was the GPs responsibility to complete any action points that may be required for that patient. Where it was likely a patient may have required support from the OOH provider e.g. palliative patients this was identified by the submission of a shared care plan.

All GPs had a lead responsibility for specific services at the practice. There were weekly clinical meetings for all the GPs, health visitors, McMillan Nurse and district nurses where reviews were undertaken. A good example of this was that of a new cancer diagnosis in a patient with a background of mental health problems.

Health promotion and prevention.

We noted that the chronic disease management was generally led by the practice nurses and supported by the GP. The continuity of care was encouraged by the practice although the GP we spoke with noted that it could be difficult to ensure continuity when there had been an

Are services effective?

(for example, treatment is effective)

emphasis on satisfying same day acute demands on appointments. There did not appear to be any formal risk stratification tools used in the practice to extract high risk patients from the population list.

We discussed the process of a new patient health check with one of the Health Care Assistants (HCA). This was a paper exercise that included a formal check of identification and went on to capture numerous demographics (as documented on the form) and included a full medical history, medication list, alcohol, smoking, and even tuberculosis (TB) screening. The HCA informed us that patients usually had to wait for around one week to have a new patient check. If a patient required intervention before then they would be seen as a temporary resident. Language line was used if a patient required a translator and this was accommodated by use of a longer appointment time.

We were told there were shared care arrangements with the local drug and alcohol misuse services to meet the needs of these patients. Plus the surgery had participated in locally led initiatives to target prescribing problems such as high benzodiazepine usage. Long-term users are prone to tolerance or physical dependence, The recent CCG initiatives for dealing with local demand had included work centered around chronic obstructive pulmonary disease (COPD) around the provision of "rescue" steroids and antibiotics, falls prophylaxis and reducing paediatric inpatient admissions. The practice provided a range of supporting information and leaflets to patients and carers in relation to services, advice and support networks available in the community. New patients were being accepted by the practice. All new patients completed a questionnaire and were given a new medical patient appointment. This enabled to practice to provide individualized care and support.

Are services caring?

Summary of findings

Overall the service was caringPatients who we spoke with who used the service were generally positive of their experience when they used Duke Street Surgery. We found the practice provided effective care to a wide range of patients who had differing needs. Patients thought the staff were friendly who cared for and responded to their needs. We saw good interaction between patients and staff and the staff treated patients with respect and protected their dignity and confidentiality.

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with patients who used the service and they told us the staff were kind and caring. We saw receptionists who spoke with patients in a kind and respectful manner. Patients we spoke with told us they felt they were treated with dignity and respect. We observed that patient's privacy was maintained even though the reception desk was located in the main area of the waiting area. We spoke with the receptionists who told us there was no specific private waiting rooms available for patients should they wish to discuss anything in private so other people could not hear. But if this was required they would accompany the patients to a free consulting room. We spoke with the practice manager about this and it had been previously identified and they were currently looking at how they could redesign the ground floor area to accommodate a room so patients could speak in confidence to non clinicians. We saw the patient waiting area was warm and comfortable with sufficient seating. There were also small toys available for the use of children.

Consultations took place in rooms which had a consulting couch for examinations and suitable disposable curtains which offered protection for patients' privacy and dignity.

The service operated a chaperone service and we spoke with staff who advised patients of this service. We saw evidence of the chaperone policy and it was clearly advertised in the reception area that a chaperone service was available. However we found the policy confusing. Practice literature informed patients of their right to a chaperone and used the words a "trained member of staff". However, the practice manager stated that there was no formal training delivered for practice staff and that this in fact could be a receptionist who would have no knowledge of the procedure involved. They would sit outside of the curtain and therefore could not view the patient or clinician during their consultation. The current policy is ambiguous and consideration should be made to it being rewritten.

Involvement in decisions and consent

Patients told us they had been involved in decisions about their care and treatment. They were given time to ask questions and felt the staff clearly explained the treatments to them. This also included information they had been given for any next steps in their treatment which had been explained to them. The practice had a consent policy in

Are services caring?

place. This policy provided staff with information about when consent was required and how it should be recorded. We were told that verbal and written consent was noted in the patients' records. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

The practice explained about a process called 'Deaf Vision' which was an organisation that was used for those who were hard of hearing. There was a loop for people who wore hearing aids. Reception staff also spoke of how they had received guidance on how to deal with violent or aggressive patients.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive to people's needs.There was an open culture within the organisation and a comprehensive complaints policy. Complaints about the service and significant events were taken seriously and were responded to in a timely manner. We saw patient and staff suggestions for making improvements had been acted on. The provider was always seeking ways to improve the services they offered. Although we noted there was some concern from patients we spoke with about access to appointments.

Our findings

Responding to and meeting people's needs

The provider had steps in place to ensure that patients who had difficult in communicating for example where English was not their first language were able to access the service. We spoke with staff who told us about the language line they could use and were familiar with the availability of the telephone service. A member of staff told us the service had been used to support the local Polish community.

We observed the staffing levels at the practice and how they had responded to the needs of the patients. In a morning at peak time there would be at least two members of staff staffing the incoming telephone calls at the reception desk. Urgent calls would be triaged by the on call GP and then if required the patients would then attend one of the available surgeries that day or as thought best by the GP.

We saw evidence of how the provider listened to staff and patients collectively. An example of this was the lack of a room so that patients could talk in confidence to non clinical staff. We discussed this with the practice manager who confirmed there had been discussions about this private room and they had looked at redesigning the ground floor to accommodate this, otherwise they used a spare room if it was available.

The practice completed a yearly patient feedback questionnaire and generally the comments were positive, and responded to the issues raised where appropriate. There was also provision where patients could complete comments about the service they received in the entrance area. Staff had identified the need for a room where they could speak with patients in a confidential manner. They had also identified they could reduce mistakes made over repeat prescriptions; they did this by utilising a member of staff in an office away from reception. This meant all repeat prescriptions could be reordered by one person away from the daily busy routine of the reception desk and this ensured mistakes were reduced.

The provider was constantly aware of changes due to comments raised at the practice by patients or other workers coming to the area within the practice and had

Are services responsive to people's needs?

(for example, to feedback?)

recently undertaken specific training in order to deal with the occupational health of offshore workers and the local factories. This also included visiting the working conditions of these workforces and their working environment.

Access to the service

Duke Street surgery was accessible to patients with mobility difficulties and also parents using prams for their children The consulting rooms were spacious and well laid out with easy access for patients with mobility issues. There were also toilets available for all patients. All surgeries were by appointment only and patients could make appointments either by telephoning the surgery or calling in at the surgery. Pre-bookable appointments were available up to four weeks in advance. A number of appointments were reserved each day for emergencies. If patients felt their problem could be dealt with over the telephone rather than visiting the surgery they could ask for a telephone appointment. The GP would then phone the patient back at an appropriate time. Patients could also be visited at home by a community nurse if they were referred by a GP. Patients could also be visited at home by a health visitor if patients recently had a baby or if they had newly registered with a GP at the practice and had a child less than five years.

The practice also provided home visits, where patients had to contact the practice before 10am. Home visits were available to patients who were housebound or too ill to attend the practice

Another example was when patients checked in on the electronic patient system to confirm their attendance at the practice, to the side of the display screen was a map of the surgery which showed where a particular clinician was based. This ensured that the patient could then go to the appropriate waiting area to wait for their appointment. This showed to us how the provider was responsive to suggestions and welcomed challenge in an open and fair way to change and improve the service. The practice had an emergency telephone line which was for use during surgery hours which was given priority

Concerns & Complaints

The practice had an effective complaints policy and procedure. We saw evidence of the complaint and how they had been recorded and responded to in accordance with their policy. We saw written complaints were responded to accordingly, investigated and responded to in a timely way and where relevant escalated to other agencies. We saw evidence of three complaints that had been received in the last 12 months. If patients were not satisfied with the outcome there was details of whom they could complain to. Where complaints had been prolonged we saw there was regular correspondence from the surgery keeping the complainant updated. We saw how the practice reviewed its complaints and detail why it happened, what had happened and what had been learned and changed as a result of this. We saw five action points had been detailed about how the practice would ensure it would not happen again.

Staff told us they tried to rectify any concerns or adverse comments immediately. They said they gave people who wished to make a complaint a copy of the procedure if the matter could not be resolved at the time.

Are services well-led?

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

Summary of findings

Overall the service was well-led.There was a visible leadership team with vision and purpose. Structures were robust and there were systems in place for managing risk. The provider welcomed challenge and promoted an open and fair culture.

Our findings

Governance arrangements

There was a strong and visible leadership team with a clear vision and purpose. The practice manager and GPs had created comprehensive systems for monitoring aspects of the service and these were used to plan future developments and to make improvements to the service.

The practice manager and GPs actively encouraged patients to be involved in shaping the service.

We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

The practice actively encouraged patients to be involved in shaping the service and there was an active patient participation group. There were processes in place to frequently review patient and staff satisfaction and we saw that action had been taken, when appropriate, in response to feedback from patients or staff. There was evidence of audits which had taken place, this meant that information could be analysed to identify any trends which could impact on the service and focused them on areas which needed development. We saw evidence of patient audits on their experience at the practice and there was a system in place whereby patients were encouraged to complete these on line or hand them to members of staff.

Staff engagement and involvement.

Members of staff we spoke with were positive about the management of the service. They felt supported and that they could approach the management team at any time. Staff also said they were encouraged to continually learn and thereby improve the service. There was an established management structure with clear areas of responsibility for all staff. Staff we spoke with had a good understanding of their areas of responsibility and ensured they took an active role in ensuring a high level of service was provided on a daily basis. We saw evidence of how management sought to learn from stakeholders especially through patient participation groups and from their members of staff.

Staff we spoke with and the documents we reviewed showed that they regularly attended staff meetings and these provided them with the opportunity to discuss the

Are services well-led?

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

service being delivered. We saw that the GPs used the meetings to share information about any changes or action they were taking to improve the service and actively encouraged staff to discuss these points.

Staff were very engaged with and committed to the surgery and its patients. They spoke passionately about their roles and their patients and how they were supported to give patients the best care possible.

Staff felt valued and confident they could raise any issues they may have with either the partners or the practice manager and it would be dealt with in an appropriate manner. We were told the staff worked well as a team and supported each other where needed.

Patients experience and involvement

The practice had a virtual Patient Participation Group (PPG) which consisted of 31 members. This was set up due to the very low response to meetings where patients did not attend. The practice used its website to try to reach the groups of patients they had previously proved difficult to reach. Patients could join the PPG by either emailing or completing a form which could be handed in at reception. Details of the ongoing survey for 2014 could be viewed on-line as well as the results the practice produced for their earlier surveys.

Learning and improvement.

The practice was committed to ongoing education, learning and individual development of people who worked at the practice. We saw examples of individual learning and supervision records. The performance of people who worked at the practice was the subject of monitoring and appraisal at all levels which reflected the organisational objectives.

There were leading roles within the team for different aspects of the service. For example, a nurse led on infection control in the practice.

We saw that a comprehensive training matrix for all staff employed in the surgery was in place and up to date. The practice was able to identify what training each staff member had received, when it had occurred and when any refresher training was due.

We spoke with staff about whistleblowing procedures and they confirmed they would raise issues with the practice manager and were confident they would be listened to. They said they would also contact the registered manager. All staff were aware of the whistle blowing policy. One member of staff said, “I would always go to see any of the managers or GPs they have an open door policy and are very approachable.”