Navenby Cliff Villages Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

The Cliff Villages Medical Practice is a rural general practice located nine miles south of Lincoln city centre. The practice serves the general local community with approximately 8,000 patients registered at the practice. The practice has two surgeries: Waddington surgery, located at Mere Road, Waddington, and Lincolnshire and Navenby surgery, located at Grantham Road, Navenby, Lincolnshire.

The practice was safe. There were systems and processes in place to ensure that both patients and staff were protected from risk. This included arrangements for safeguarding children and vulnerable adults. There were appropriate arrangements in place for out of hours cover when the practice was closed. Medicines were managed safely and the practice had good arrangements in place for responding to emergencies.

The practice was effective. There were policies and procedures in place to ensure that care and treatment was delivered to an appropriate standard. There were clinics in place for several long-term conditions, such as asthma and diabetes, and health promotion support and advice was also available for a range of medical and health-related conditions.

The practice was caring. Patients were treated with compassion, dignity and respect. The majority of patients we obtained comments from said they felt well cared for at the practice and said they had confidence in their GPs. There were close links with the care homes in the area.

The practice was responsive. There was an efficient triage system, which allowed a GP to assess how best to meet the needs of a patient by first speaking to them on the phone. Both surgeries were accessible to patients with mobility issues. The practice also provided medical services to patients at a learning disability assessment and treatment unit near Lincoln.

The practice was well led. A patient survey completed in August 2013 had identified some areas for improvement and there was evidence that the practice had either addressed the issues identified or was in the process of addressing them.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. Systems and processes were in place to ensure that both patients and staff were protected from risk.

The practice had safeguarding procedures for identifying and dealing with vulnerable people, and staff had received the necessary training to ensure patients' safety.

We identified that there were systems in place to deal with emergencies, and equipment to be used in the event of a medical emergency was checked regularly to ensure that it worked efficiently and effectively.

Patients who we talked with said that they felt safe.

Significant events at the medical practice were reviewed by the GPs and learning points were passed down through the staff team. There was a system for clinical audit in place and this led to improvements in the quality of care on offer.

Are services effective?

The practice was effectively meeting a wide range of patient needs.

There were clinics in place for people with long-term conditions, such as asthma and diabetes, and patients were referred to these clinics by the GPs for on-going support and treatment.

We found that staff records relating to recruitment, training and support were not available for inspection. Staff said that they felt well supported and trained; however, without the evidence this was not possible to evaluate.

The practice had a website and had made this accessible to its patients by having a section for non-English speaking patients. This gave key information in English and twenty additional languages.

Are services caring?

We found that the practice was caring.

We spoke with several patients during our inspection. We received many comments from patients expressing their satisfaction and stating they received good care. There were a few negative comments, but the positive comments far outweighed the negative comments in number. This was further reflected by the medical practice's own survey the results, which were available on their website.

Summary of findings

We also spoke with staff at a number of care homes in the area who received a service from the practice. All of the comments received from the care homes were positive, and staff reported that the residents in the care homes received good care from the GPs at the practice.

The practice had taken measures to ensure that patients' dignity and privacy was respected at the reception desk. At both surgeries we saw that a private room was available for patients to talk to the receptionist if required.

Are services responsive to people's needs?

The practice was responsive to patients' needs. The practice had an efficient triage system, which allowed a GP to speak to patients who wanted an appointment to assess how best to meet their needs and direct them to the most appropriate healthcare professional.

Patients told us that referrals to other agencies or areas of the NHS were made quickly and efficiently and important information was passed on to those other carers.

The practice used an out of hours service to cover for evenings, weekends and public holidays. This meant that patients had access to medical advice and support even when the surgeries were closed. Information about patients seen during the out of hours periods was passed efficiently to the medical practice.

We saw that clinical staff made appropriate referrals to other healthcare professionals, for example the local hospital, where necessary. This meant that patients did not experience undue delay, and were seen by the appropriate healthcare professional to meet their needs.

Are services well-led?

The practice was well-led. There was a system of clinical audit in place at the medical practice. This meant that the GPs were looking to evaluate the care provided and consider ways in which that care could be improved.

Staff said they were happy working at the medical practice, they felt part of a team and felt well supported.

Complaints were discussed at a senior level within the practice and responded to appropriately. However, information on how to complain for patients was not always available.

Summary of findings

What people who use the service say

Before our inspection visit we left comment cards at the practice, which were returned by four patients. In addition, an Expert by Experience was part of our inspection team, who spoke with 16 patients across both surgeries during the inspection visit.

Most patients said they were happy with the care and service that they had received. Comments about the appointment system showed that it was usually possible to get an urgent appointment, although routine matters or appointments with a specific doctor might take up to two weeks. Several people commented on the triage system (this is where patients talk to a doctor on the telephone, and a decision is made whether the patient needs an appointment and if so how quickly.) Patients said that they liked the triage system, and preferred talking to a doctor rather than explaining their problem to a receptionist.

Few of the patients we spoke with were aware of the complaints procedure. This was because the complaints procedure was not on display in either waiting room, although an information sheet was available on request from reception. If patients wanted to make a complaint or were unhappy, most said they thought they would either speak to the doctor or ask to speak to a senior member of staff at the reception desk.

Many of the patients felt the practice staff knew them well, and were also happy with the doctor–patient relationship. Several patients said that they felt comfortable discussing their health issues with the doctors, and felt listened to and taken seriously. Several patients also identified that they had needed a referral to a specialist or for further treatment, and this had happened quickly and efficiently.

Most patients we spoke with felt their privacy and dignity was taken seriously. We were told that patients felt there was room at the desk for them to speak privately, and we were given examples of healthcare staff (doctors and nurses) promoting people's dignity through their words and actions.

Few of the patients we spoke with were aware of the patient participation group (PPG). The PPG is a volunteer patient led group that meets quarterly to discuss the services on offer and how improvements can be made. There was a PPG noticeboard in each waiting room; however, it was not in a prominent position. As a result, few of the patients were aware the PPG existed.

Patients identified that they felt they had an effective GP service. Feedback received through a professional survey carried out by the practice and through face-to-face discussions with patients supported the view that most patients were happy with their GP service and thought that their needs were being met. The professional survey received 227 responses out of a patient list of 7,940 patients.

Areas for improvement

Action the service COULD take to improve

The medical practice could review its complaints procedures and make them more accessible to the patients who use its services.

The records relating to staff recruitment could be improved as it was not possible to demonstrate that there were reliable systems, processes and practices in place to keep people safe and safeguarded from abuse.

Information relating to staff recruitment checks could be clearer. With staff recruitment checks monitored and audited, to ensure that any gaps are identified and rectified. This would demonstrate that systems were safe and robust.

Clearer recording of staff appraisals would ensure that staff development could be monitored in a clearer and more co-ordinated manner. This would lead to safer and better patient care.

Navenby Cliff Villages SurgeryCliff Villages Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and a GP. The team included another experienced CQC inspector, a specialist advisor with a primary medical care background and an Expert by Experience who helped us to capture the experiences of patients who used the service.

Background to Navenby Cliff Villages Surgery

Cliff Villages Medical Practice has approximately 8,000 patients registered across two surgeries in a rural area south of Lincoln. One surgery is situated in the village of Waddington and one approximately 5 miles to the south in the village of Navenby. Both surgeries are located in purpose built premises with car parking available. The patient areas in both surgeries are on the ground floor and there is level access for patients.

At the time of our inspection visit Cliff Villages Medical Practice had four GPs. Three were working full time and one part time. The practice also employed two registered nurses and two healthcare assistants. The clinical staff were supported by a practice manager and a team of reception and administration staff.

This was our first inspection visit to the Cliff Villages Medical Practice. There was an RAF camp located close by, and and many of the working aged people in the area received their primary medical care from the RAF rather than the Cliff Villages Medical Practice. This meant that there was a slightly higher than average ratio of older patients compared to people of working age when compared with similar sized practices elsewhere.

Both surgeries were dispensing surgeries with a dispensary located on-site. For those patients who were not eligible to receive their medication at the medical practice there were a number of commercial pharmacies within the area.

Why we carried out this inspection

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

How we carried out this inspection

We visited the practice on 29 April 2014. We spoke with doctors, nurses, and other staff, and also with 16 patients. We looked at the practice's procedures and systems and considered whether Cliff Villages Medical Practice was safe, effective, caring, responsive to people's needs and well-led.

Detailed findings

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 practice and asked other organisations to share what they knew about the service.

We made an announced visit to the Cliff Villages Medical Practice on 29 April 2014. During our visit we spoke with 10 members of the staff team, including the registered manager, practice manager, nurses, general practitioners, and those staff that dealt directly with patients, either by telephone or face to face.

We spoke with 16 patients who used the service. We reviewed comment cards where patients had

shared their views and experiences of the service, as well as information that had been given to us by the practice or that was available in the public domain. We also contacted four care homes in the local area who received a service from the medical practice.

Are services safe?

Summary of findings

The practice was safe. Systems and processes were in place to ensure that both patients and staff were protected from risk.

The practice had safeguarding procedures for identifying and dealing with vulnerable people, and staff had received the necessary training to ensure patients' safety.

There were systems in place to deal with emergencies, and equipment to be used in the event of a medical emergency was checked regularly to ensure that it worked efficiently and effectively.

Patients who we talked with said that they felt safe.

Significant events at the medical practice were reviewed by the GPs and learning points were passed down through the staff team. There was a system for clinical audit in place and this led to improvements in the quality of care on offer.

Our findings

One of the GPs was the safeguarding lead for both vulnerable adults and children. We were told that all staff had received training in safeguarding children, and most staff had also received training in safeguarding vulnerable adults. However, we did not see full documentation to support this. One of the GPs told us that there were very few 'looked after children'(those in the care of the state, usually through the local authority, including children who are subject to a care order and those receiving a short break or respite care) at the medical practice. The small number of looked after children were known to the GPs and were seen on a regular basis to ensure their welfare. The staff members we spoke with said they had completed safeguarding training and were aware of safeguarding responsibilities for both children and adults. However, we did not see any supporting documentation. Staff were able to describe what to look for and what action to take. Which supported the view that staff had received training despite the lack of documentary evidence available.

The practice had a chaperone policy, which we discussed with two members of staff. We were told that several members of staff had been trained as chaperones; however, it was usually a nurse who performed this role. A female patient said "I've always had a female chaperone for any intimate examinations". This showed that the medical practice took care to protect both its patients and its staff by ensuring that neither were placed in a vulnerable or high-risk position.

Vaccines were stored below eight degrees centigrade within a refrigerator so they did not become ineffective due to a rise in temperature. The practice had a system that recorded the refrigerator temperature every two minutes and sent information to the practice's computer to alert staff if there had been a power failure during the night or over the weekend when the surgery was unmanned. We saw the records within both surgeries that showed the crucial temperatures in all of the refrigerators had been maintained. This showed that staff could have confidence that vaccines stored within the refrigerator were still viable, and this contributed towards patient safety.

Both surgeries within the practice were dispensing surgeries, with approximately 20% of the patients eligible

to receive their medication directly from the surgery. The remaining 80% were able to use commercial dispensing chemists close by. We saw that medication was well organised and dispensed safely at both surgeries.

We saw that blood samples were appropriately bagged and staff had taken the necessary precautions when handling them. Staff said that they were aware of the risks and procedures to minimise those risks, and acted accordingly. This meant that both patients and staff were protected from the risk of harm.

Curtains were in place within the consulting rooms to protect patients' privacy and dignity. Many care settings have installed disposable curtains to cut down the risk of cross infection between patients. The curtains at this medical practice were not disposable. We discussed this with the practice manager who said that the curtains were laundered regularly using an anti-bacterial washing powder. The practice manager also said that there were very few invasive procedures carried out, which meant that the curtains presented a low risk.

Hand sanitizers were available in both reception areas, and personal protective equipment such as gloves and aprons were available for all clinical staff. This meant that efforts had been made to protect both patients and staff from the risks of cross infection.

A waste management contract was in place, and we saw that clinical waste was collected and disposed of professionally. There was a separate clinical waste room at Navenby surgery where clinical waste could be stored prior to collection, which helped reduce the risk of contamination and cross infection. We noted that a sharps bin in a clinical area had not been assembled correctly, and had not been signed and dated. This could mean that sharps such as glass and needles were not being stored safely.

We reviewed the staffing records for several members of staff. Many of the staff had been in post for several years and there was a low staff turnover. We saw that there were some gaps in the recruitment sections of the staff files, with references being missing in some files. As a result, the practice was not able to demonstrate that patients were protected through safe and reliable recruitment procedures.

The nurses employed at the practice had been subject to both a disclosure and barring scheme check (DBS) and a Nursing and Midwifery Council (NMC) check. This was to ensure that the nurses were of good character and that their (NMC) registration was up to date. The nurses' files also contained application forms, and proof of identification and qualifications.

The practice manager told us that reception and administration staff did not have a DBS check, but that risk assessments were being implemented, and going forward DBS checks for all staff would be introduced in line with best practice.

The medical practice had a defibrillator, which is a machine used in an emergency to provide a shock to restart the heart. The practice manager said the training for defibrillation and life support had recently expired (March 2014) and was due to be booked.

We spoke with the practice manager about emergencies. This was both medical emergencies and emergencies that might affect the service, for example heavy snow fall or a power failure. A file had been produced and was available within the medical practice with key telephone contacts and other important and useful information to be used in such an emergency. This meant that important information and guidance was available to staff in emergency situations. The practice was located in a rural area of Lincolnshire and the practice manager said that in cases of extreme weather, such as snow, local farmers had been very helpful with snow clearing, allowing the surgeries to continue to offer a service.

We saw that the electrical safety certificates and gas safety certificates dated 29 January 2014 were available. We also saw that portable appliance testing (PAT testing) had been completed in July 2013. This meant that staff could have confidence in the electrical equipment within the surgeries. We also saw that there was a contract with British Oxygen Company (BOC) for the supply and maintenance of the oxygen cylinders in use in the surgeries.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effectively meeting a wide range of patient needs.

There were clinics in place for people with long-term conditions, such as asthma and diabetes, and patients were referred to these clinics by the GPs for on-going support and treatment.

We found that staff records relating to recruitment, training and support were not available for inspection. Staff said that they felt well supported and trained; however, without the evidence this was not possible to evaluate.

The practice had a website and had made this accessible to its patients by having a section for non-English speaking patients. This gave key information in English and twenty additional languages.

Our findings

The practice was effectively meeting a wide range of patient needs.

There were clinics in place for people with long-term conditions, such as asthma and diabetes, and patients were referred to these clinics by the GPs for ongoing support and treatment.

We found that most staff records relating to recruitment, training and support were not available for inspection. Staff said that they felt well supported and trained; however, without the evidence this was not possible to evaluate. We did however, see that apprentice staff recruited through a local college had been vetted by the college.

The practice had a website and had made this accessible to its patients by having a section for non-English speaking patients. This gave key information in English and twenty additional languages.

Our findings

The practice provided a service to a cross section of society from mothers with young children to older people. We spoke with several patients from a range of ages and backgrounds and most patients' thought that their needs were being met.

The practice has four care homes within its area. We contacted the care homes and received a positive response to our questions about the care they received. We were told that a GP visited each home once a week and held a surgery there. A staff member at one of the care homes said: "They are absolutely brilliant, I couldn't do my job without the support of the GP practice." Staff at another care home said: "All the residents like the GP. We recently had a new resident and when the GP visited he took 15–20 minutes to talk to them to get to know them. He will always go the extra mile."

In addition, the practice supported a learning disability service based near Lincoln. This was an assessment and treatment unit. The manager of the unit said that they received a regular service, and the practice was very supportive. Many of the residents had ongoing health needs and, therefore, saw the GPs regularly. The manager said that the GPs used the 'silverlink system' to record patient information and ensure that there was continuity between the GPs.

Are services effective?

(for example, treatment is effective)

We saw that each GP had a practice iPad where they were able to store policy documents and safeguarding and other internet links. This meant that even if they were away from the surgery the GPs had access to relevant information, policies and guidelines.

Before our visit we received statistical information from NHS Lincolnshire West Clinical Commissioning Group (CCG). This information suggested that there might be a problem with the over prescribing of non-steroidal anti-inflammatory drugs (NSAIDs). These are drugs that would usually be used as a painkiller or to reduce swelling. One of the GPs explained that the higher than average number of older patients would account for this. Patients in the older age group could be suffering from conditions such as arthritis, which would be treated by pain killers and anti-inflammatories. With a high number of older patients this could account for the higher statistic.

A GP said that if the out of hours service had seen a patient from the practice they sent the reports directly into the clinical system early in the morning. The GP felt that this helped with communication and maximised the continuity of care.

Further statistical information from the CCG suggested that fewer patients with atrial fibrillation were prescribed anticoagulants. Atrial fibrillation is a condition affecting the heart and is associated with an increased risk of stroke, which would commonly be treated with an anticoagulant drug such as Warfarin. The GPs explained that the reason for caution with the use of anticoagulants was that Warfarin carried additional risks for older patients. We saw that there were details of Warfarin clinics on the practice's website. This meant that patients affected by this condition were getting the information they would need to make an informed choice, and discuss with a healthcare professional.

The CCG's statistical information also suggested that the amount of advice given to patients on stopping smoking was low. However, we saw that there was an effective smoking cessation clinic held at both surgeries. We saw how patients' progress was monitored and reviewed, and there were a number of different approaches in the nurses' stop smoking strategy.

Further statistical information from the CCG suggested that there was a low number of health checks for patients on the mental health register. The GPs told us that numbers of patients with mental health needs within the medical practice was low. This meant that the small number of patients could induce a higher percentage swing in the statistics. In addition, if a patient did not wish to attend for a health check this would affect the statistics.

We saw that each member of staff had a training portfolio relevant to their duties and responsibilities. The practice manager said that staff training was recorded online at Bluestream Academy. Staff members were able to log on and access their training records. However, it was not possible for the CQC inspection team to access these training records on the day of our inspection. We spoke with a member of staff who said they had completed the required training and that annual refresher training was available. However, the inspection team did not see any documentary evidence so could not confirm this. We saw a small number of staff training records held by individuals rather than the practice. These showed what training staff members had completed. However, dates were not available, so it was not possible to judge if the training was in date or in need of refreshing and updating.

We spoke with one practice nurse who said that they felt well supported. They told us they had received an appraisal in the last year; however, we were not able to find a written record to support this. We spoke with another member of staff who said they had an appraisal within the last year and we saw documentation dated March 2014 to support this. The same member of staff said that they felt supported by the whole team, including management staff. They said that management were approachable and felt that there was support with any problem or training requirement. We also saw a list that showed new staff had completed an induction. More complete records relating to staff training and appraisal would enable the practice to better monitor its staff competencies.

The practice manager said they were aware they were behind schedule with completing staff appraisals. However, plans were in place to complete them.

GPs were not specifically allocated to oversee any particularly vulnerable groups of patients, although we were told that this had been discussed and the GPs were considering this option. We saw that, in line with the Secretary of State for Health's announcement in 2013, all patients over the age of 75 had a nominated GP.

Are services effective?

(for example, treatment is effective)

A named GP ran a diabetic clinic. Another GP had an interest in cardiovascular problems. A third GP had a special interest in respiratory problems. Each GP had a nurse-led clinic, with the exception of cardiovascular problems, which were shared by all of the GPs. We saw information relating to long-term conditions such as asthma and diabetes was available on the medical practice's website, with links to other websites offering more information and advice.

The Cliff Villages Medical Practice website could be translated into 20 other languages in addition to English at the click of a button, which meant that any non-English-speaking patients would be able to find information and access services through the website, even if English was not their first language.

Prior to our inspection we received information that nationally female patients were not being routinely recalled for cervical cancer smear tests. We discussed this with a GP and saw that this did not present a problem at this surgery. We saw that patients would be monitored and recalled if necessary.

Are services caring?

Summary of findings

We found that the practice was caring.

We spoke with several patients during our inspection. We received many comments from patients expressing their satisfaction and stating they received good care. There were a few negative comments, but the positive comments far outweighed the negative comments in number. This was further reflected by the medical practice's own survey the results, which were available on their website.

We also spoke with staff at a number of care homes in the area who received a service from the practice. All of the comments received from the care homes were positive, and staff reported that the residents in the care homes received good care from the GPs at the practice.

The practice had taken measures to ensure that patients' dignity and privacy was respected at the reception desk. At both surgeries we saw that a private room was available for patients to talk to the receptionist if required.

Our findings

As part of the inspection team we had an Expert by Experience. This was a person who had experience of care services and used their knowledge and experience to gain an insight from patients into the care they had received. We also left a comments box, with cards for patients to give feedback about their care.

We received four comment cards, and the comments were all positive; for example: "10/10", "Excellent", "I have found everyone extremely professional and caring in every way", "I have found the doctors caring and they listen to my problems". Four comment cards was not representative of the patient group. However, the reception staff said that most patients had declined to fill in a comment card even when they were brought to their attention by the reception staff.

Our Expert by Experience was given mostly positive comments, although not all. The positive comments included:

"All staff treat me with respect. I can easily ask questions if there is anything I don't understand."

"I was supported very well by the surgery when my wife died."

"I feel part of the decision-making process and I'm always given the options."

"The staff are respectful and polite."

"My privacy and dignity is respected. The GPs go away while I am dressing and undressing."

"I am given choices and options about treatment."

A younger patient said: "I find the doctor helpful and not scary. The doctor always tells me what he is going to do and gives me advice about my asthma."

"The staff are very considerate of older people. We are treated with respect and sympathy."

These comments showed that patients felt they received good care and were involved in the decision-making process around the care.

However, some patients were not entirely satisfied and said:

Are services caring?

"Sometimes I feel I'm not listened to. I know from experience what I need, and often don't get it. I've tried to talk about my problems, but I feel like a number."

Within the both surgeries we saw that there was loop system in place to help those patients who used a hearing aid to hear better and to understand what was being said. The reception areas were arranged in such a way as to provide a degree of confidentiality. There was a rope barrier to ensure that patients who were waiting were not too close to overhear the discussions at the desk. Music was also playing to cover the sound of patients' voices, and protect privacy and dignity. Private rooms were available should a patient wish to speak to the reception staff privately.

We spoke with staff at several care homes supported by the practice. We were told that the GP completed advance care plans for end-of-life care in line with the Mental Capacity Act (2005) and, when appropriate, reviews of those care plans were increased to three-monthly, monthly, weekly or daily, as necessary.

The care homes also talked about 'Do not attempt resuscitation' (DNAR) forms for residents. A purpose of a DNAR form was to allow patients and those close to them to record their wishes in preparation for the time of their death. The GP would consider the request but first discuss it fully with the patient and their family. Where the GP did not think a DNAR was appropriate they would explain why, supporting the individuals' choices and consent.

Another care home who used a different GP said: "The GP holds a weekly surgery at the home on a Wednesday. The GP is very supportive and has a very good bedside manner."

To protect patients' dignity we saw that there was a hatch from the patients' toilet area straight into reception. This meant that patients did not have to hand their samples over at the front desk.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. The practice had an efficient triage system, which allowed a GP to speak to patients who wanted an appointment to assess how best to meet their needs and direct them to the most appropriate healthcare professional.

Patients told us that referrals to other agencies or areas of the NHS were made quickly and efficiently and important information was passed on to those other carers.

The practice used an out of hours service to cover for evenings, weekends and public holidays. This meant that patients had access to medical advice and support even when the surgeries were closed. Information about patients seen during the out of hours periods was passed efficiently to the medical practice.

We saw that clinical staff made appropriate referrals to other healthcare professionals, for example the local hospital, where necessary. This meant that patients did not experience undue delay, and were seen by the appropriate healthcare professional to meet their needs.

Our findings

The practice was based at two sites, approximately five miles apart. Apart from a Monday morning when both surgeries were open, the service alternated between one site and the other. This meant the service could reach a greater part of the practice area; however, this was not always at a time of the patient's choice. One patient said: "It's not easy to get an appointment that fits in with work time". Another comment from a patient on the practice's website was: "I have no problem with the doctor but Navenby surgery is not open enough. So much money spent on building it, and very difficult to see a doctor when needed. Not everyone can travel to Waddington." This meant that the surgery's opening times did not always suit every patient.

In response to concerns raised by patients, the medical practice had changed its telephone number from 31 January 2014. The new telephone number gave patients access to a local telephone number. We received comments from two patients who said this had been a great improvement. This meant that the medical practice had listened to patients' concerns and responded to them.

We saw that there was a well organised triage system. A GP telephoned patients to discuss their need for an appointment. This enabled the GP to assess whether they needed to be seen urgently, whether they needed to see a GP or a nurse, or whether the problem could be resolved over the telephone, saving time for both the patient and the GP later in the day. This meant that there was an efficient allocation of resources.

The GP who was operating the triage system on the day of the inspection said that they had spoken with 40 patients in a two hour period that day; however, they said the numbers could rise much higher on really busy days. Patients said: "I like the triage system" and "I can get an appointment the same day if it's important. Routine things take longer, about two weeks usually."

There were three full time doctors and one part time doctor. Locum doctors were not routinely booked, as the medical practice covered its own short term sickness, meetings, and holidays. However, locums had been used to cover prolonged sick leave or maternity leave. This meant that there was consistency with regard to how the GPs responded to the patients' needs.

Are services responsive to people's needs?

(for example, to feedback?)

Two patients said they had been referred to the local hospital for further treatment. In both cases patients said they were referred quickly and efficiently. Both also said that when they got to hospital the doctor who saw them was aware of their problem, having received details from the practice.

We asked staff on the reception desk about the complaints procedure. Staff were able to locate the procedure quickly and knew how to respond if they received a complaint. We did not see a copy of the complaints procedure on display in any of the public areas of either surgery. When asked, reception staff said they would give anyone who asked a printed sheet, which directed them to contact the practice manager. The printed sheet did not give details of whom the complainant should contact if they were not happy with the practice's response. On the practice website the section headed 'complaints' directed anyone wishing to make a complaint to "write to the practice manager".

We asked patients about complaints and were told: "I don't know what the practice's complaint's procedure is", "I would know how to make a complaint as I have a relative who is a doctor", "I'm not aware of the complaints procedure", "I've never made a complaint, I've never needed to". This suggested that it was not clear to all patients how to make a complaint. Some patients said the medical practice's website was not very helpful as it said to ask for a copy of the policy from reception or write to the practice manager. The website did not give detailed information, or have a copy of the procedure. We also found that those patients who might require assistance with making a complaint would not necessarily find it easy to do so.

We saw that the practice had received four complaints in the past year. The practice had responded to all four complainants appropriately in writing. The lessons learned from the complaints had not been minuted in staff meetings, but there were records of the action that would be taken following two of the complaints.

A number of patients were unhappy with the surgery opening times and wanted to see the surgeries open for longer in each location.

Throughout our inspection visit we saw evidence of patients being referred for further treatment or specialist advice when necessary. We were told by several patients that they had been referred to the hospital for further tests or treatment, and this had happened quickly. One patient said: "I had a good service, and things were picked up and acted upon quickly".

The practice did not open at weekends and closed at 6.00pm, except on Tuesdays when the surgery at Navenby opened until 8.30pm. Patients who required medical attention outside of the surgery opening times were directed to use the out of hours service, either by ringing 111 or by ringing the practice and selecting option one. This meant that patients had access to medical advice 24 hours a day, 7 days a week, including when the surgeries were closed.

During our inspection we saw that the practice had a patient participation group (PPG) and we met with two members of the group. The PPG had been running for approximately two years and met quarterly. The members of the PPG were trying to support the medical practice and improve communication. Both PPG members provided positive feedback about the medical practice and its services. We saw that there was a PPG noticeboard in the waiting rooms at both surgeries. Information about the PPG was also available on the practice's website.

Are services well-led?

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

Summary of findings

The practice was well-led. There was a system of clinical audit in place at the medical practice. This meant that the GPs were looking to evaluate the care provided and consider ways in which that care could be improved.

Staff said they were happy working at the medical practice, they felt part of a team and felt well supported.

Complaints were discussed at a senior level within the practice and responded to appropriately. However, information on how to complain for patients was not always available.

Our findings

The practice was led by a team of four GPs and a practice manager. We found that there was a well-led administration, and that all staff knew and understand their role. We spoke with several staff members during our inspection visit and found that staff were able to answer questions about the practice and how it was managed. We saw that staff were calm and there was a relaxed atmosphere in both surgeries.

We discussed significant events with a GP. We saw that they were recorded and audited, and that they were discussed at both clinical and team meetings. This was to learn from the events and take steps to prevent them from happening again. We found that each of the clinicians carried out audits as part of their GP revalidation. This was part of their self-directed appraisal system. The results of the audits were discussed, and any changes that were needed were discussed and implemented through the clinical meetings. This meant that the GPs were evaluating the quality of their medical practice and taking steps to ensure improvements.

There was a lead GP for clinical governance, which is a systematic approach to maintaining and improving the quality of patient care within a health system. We saw that clinical governance was discussed at meetings, and information and learning was passed down through both clinical and team meetings. Clinical team meetings were held monthly at the practice.

We spoke with several members of staff who said that they felt able to raise concerns or make suggestions. Staff also felt that when they had raised concerns or suggestions they had been listened to and acted upon. We spoke with one member of the reception team who said: “I like working here it is a very supportive team”.

Discussions with staff in the administration and reception departments showed that regular meetings were taking place at the practice. These type of meetings were: practice meetings, GP meetings, and nurses meetings. However, we found that the minutes of those meetings were often not recorded. As a result there was no documentary evidence to support that the meetings had taken place. We saw that there were some meeting minutes and agendas available; however, these were not for all meetings. We had to take a lot of information on word alone, though from several different sources.

Are services well-led?

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

In August 2013 the practice used the services of an external company that specialised in patient feedback in medical services. The company produced an 'improving practice questionnaire' and received 227 responses from the 7,940 patients registered at that time. The questionnaire and the evaluation of the results were available on the website. The practice manager told us that some of these issues had been addressed (for example changing the telephone number to a cheaper rate) and others were being addressed.